

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08250

CERTIFICATE OF DEATH

08238

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RT#5		c. LENGTH OF STAY IN TB 4 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGDALE ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA IRENE (RUBY) ALBERT		4. DATE OF DEATH JUNE 11 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 18 1899
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE (WORKED IN CANNING FACTORY)		10b. KIND OF BUSINESS OR INDUSTRY FRED. CO. MD	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES HAINES		14. MOTHER'S MAIDEN NAME EMMA MAE FRITZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-6693	
17. INFORMANT Walter J. Albert		Address WESTMINSTER MD-1 RD#5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO (b) Seen by Dr. Glen Sprecher Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) on 5/24/66		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic CVD		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/2/64 , 19__ to 6/11/66 , 19__, that (I) (we) lost saw the deceased alive on 12/2/64 19__, and that death occurred at 4:20 P.M. from causes on and on the date stated above.			
22a. SIGNATURE M.E. Roberts		22b. DATE SIGNED 6/11/66	
22c. PHYSICIAN'S NAME (Type) M.E. ROBERTSON M.D.		22d. ADDRESS New Windsor, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/14/66	
23c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEM.		23d. LOCATION (City or Town) (County) (State) UNIONVILLE, FRED CO. MD.	
24. FUNERAL DIRECTOR J. S. Myers Jr., Westminster, Md.		25a. REC'D BY REGISTRAR JUN 14 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08530

08530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08251

CERTIFICATE OF DEATH

08239

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 5 mos. 6 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11802 Georgia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE (nmn) BARANSKI				4. DATE OF DEATH Month Day Year June 8 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-94	
9. AGE (In years lost birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Augustofski				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.						INTERVAL BETWEEN ONSET AND DEATH days days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-2-66 , 19 66 , that (I) (we) last saw the deceased alive on 6-8-66 , 19 66 , and that death occurred at 12:00 noon M, from causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo. 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22b. DATE SIGNED 6-8-66 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-11-66		23c. NAME OF CEMETERY OR CREMATORY St. Ladislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Allegany Co. PA.	
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.				25a. REC'D BY REGISTRAR JUN 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

08320

12280

JUN 11 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08252

08240

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster R.T. #5</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospital</u>			d. STREET ADDRESS <u>Wooddale</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ORA</u> Middle <u>MAY</u> Last <u>BEACHAM</u>			4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27 1898</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Thomas Surle</u>			14. MOTHER'S MAIDEN NAME <u>Millie Annison</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-4352</u>	17. INFORMANT <u>P. Shingluff Beacham</u> Address <u>Same</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>66</u> , to <u>6/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/26</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Vincent J. Kuroda Jr.</u>			22b. DATE SIGNED <u>6/27/66</u>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens</u>	23d. LOCATION (City or town)	(County)	(State) <u>Frederick, Md.</u>
24. FUNERAL DIRECTOR <u>E.S. Myers, Jr.</u>			25a. REC'D BY REGISTRAR DATE <u>JUN 30 1966</u>		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

04330

RECEIVED OF DEATH

04330

2000

Capital Co. 2000

MAY 1900

2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and they must be filed within 72 hours after death.

VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08253

CERTIFICATE OF DEATH

08241

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
c. LENGTH OF STAY IN 1b 2 weeks		d. STREET ADDRESS 906 Shirley Manor Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co., General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA F. BEALL		4. DATE OF DEATH Month June Day 18 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William D. Butler		14. MOTHER'S MAIDEN NAME Elsie M. Bair	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-0624	
17. INFORMANT George R. Beall Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) 2 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma, severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 7, 1966 to June 18, 1966 , that (I) (we) last saw the deceased alive on June 18, 1966 , and that death occurred at 6:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey		22b. DATE SIGNED 6/18/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY		22d. ADDRESS 84 Anchor St. Westminster, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-21-1966	23c. NAME OF CEMETERY OR CREMATORY St. James	23d. LOCATION (City or Town) (County) (State) Carroll Co., Maryland
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.		25. REC'D BY REGISTRAR JUN 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10380

02330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be placed for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN lb <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>73 Manchester Ave</u>						d. STREET ADDRESS <u>73 Manchester Ave</u>					
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>MABEL</u> Middle <u>BEAVER</u> Last						4. DATE OF DEATH Month <u>JUNE</u> Day <u>2</u> Year <u>1966</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Clayton S. Groat</u>						14. MOTHER'S MAIDEN NAME <u>Bertie Youngling</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-12-1102</u>		17. INFORMANT Name <u>M. Floyd Beaver</u> Address <u>73 Manchester Ave, Westminster Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Cardiovascular dis. with Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none, but obesity</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 hours</u> <u>2 years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15</u> , 19 <u>66</u> to <u>6-2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-1</u> , 19 <u>66</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>C. H. Billingslea</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>6-2-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>C. H. Billingslea</u>						22d. ADDRESS <u>Westminster, Md. 6-2-66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City, town or county) _____ (State) _____ <u>Westminster, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10581

OFFICE OF CLARK

10581

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08255

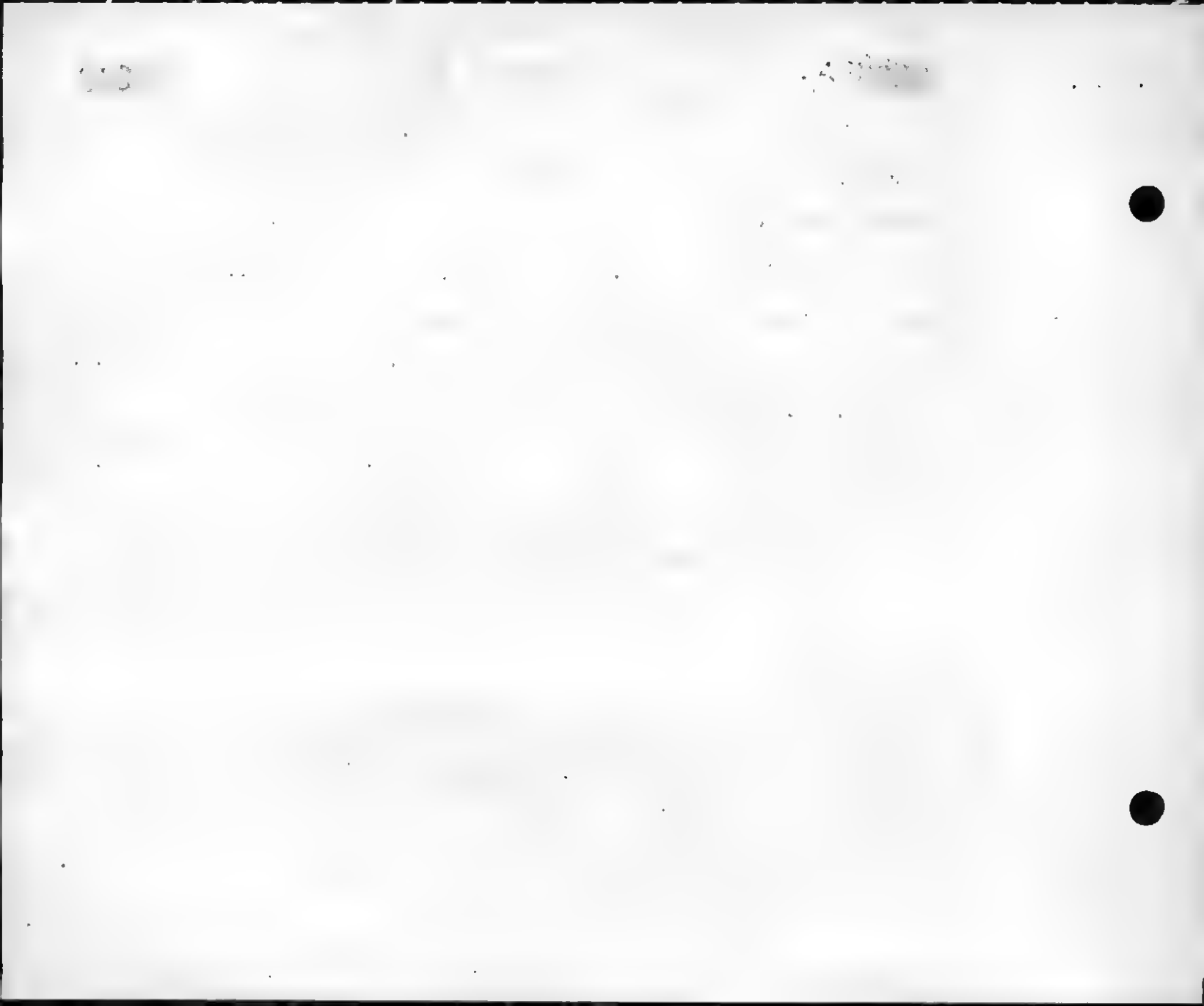
CERTIFICATE OF DEATH

08243

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pullen Nursing Home		d. STREET ADDRESS Shipes Lane	
3. NAME OF DECEASED (Type or print) First Sadie Middle F. Last Berryman		4. DATE OF DEATH Month 6 Day 26 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1881
9. AGE (in years last birthday) 85		IF UNDER 1 YEAR Months 12 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Balto. City		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME David E. Little		14. MOTHER'S MAIDEN NAME Mary M. Scharf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr Gilbert M. Berryman		Address Kenmar Ave Garrison P.O. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4 3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Detonated C.V.D. DUE TO (c) Heart Block			INTERVAL BETWEEN ONSET AND DEATH 12 months 19 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 17, 1966 to June 26, 1966 , that (I) (we) last saw the deceased alive on June 18, 1966 , and that death occurred at 4:30 PM , from causes and on the date stated above			
22a. SIGNATURE Sani Okutman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 6.27.66
22c. PHYSICIAN'S NAME (Type) Dr. A. Sani Okutman		22d. ADDRESS Obrecht Rd Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/29/66	23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial	23d. LOCATION (City or Town) (County) (State) Carroll Md.
24. FUNERAL DIRECTOR Strong Byers 8728 Liberty Rd		25a. REC'D BY REGISTRAR Randall DATE JUN 30 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

707

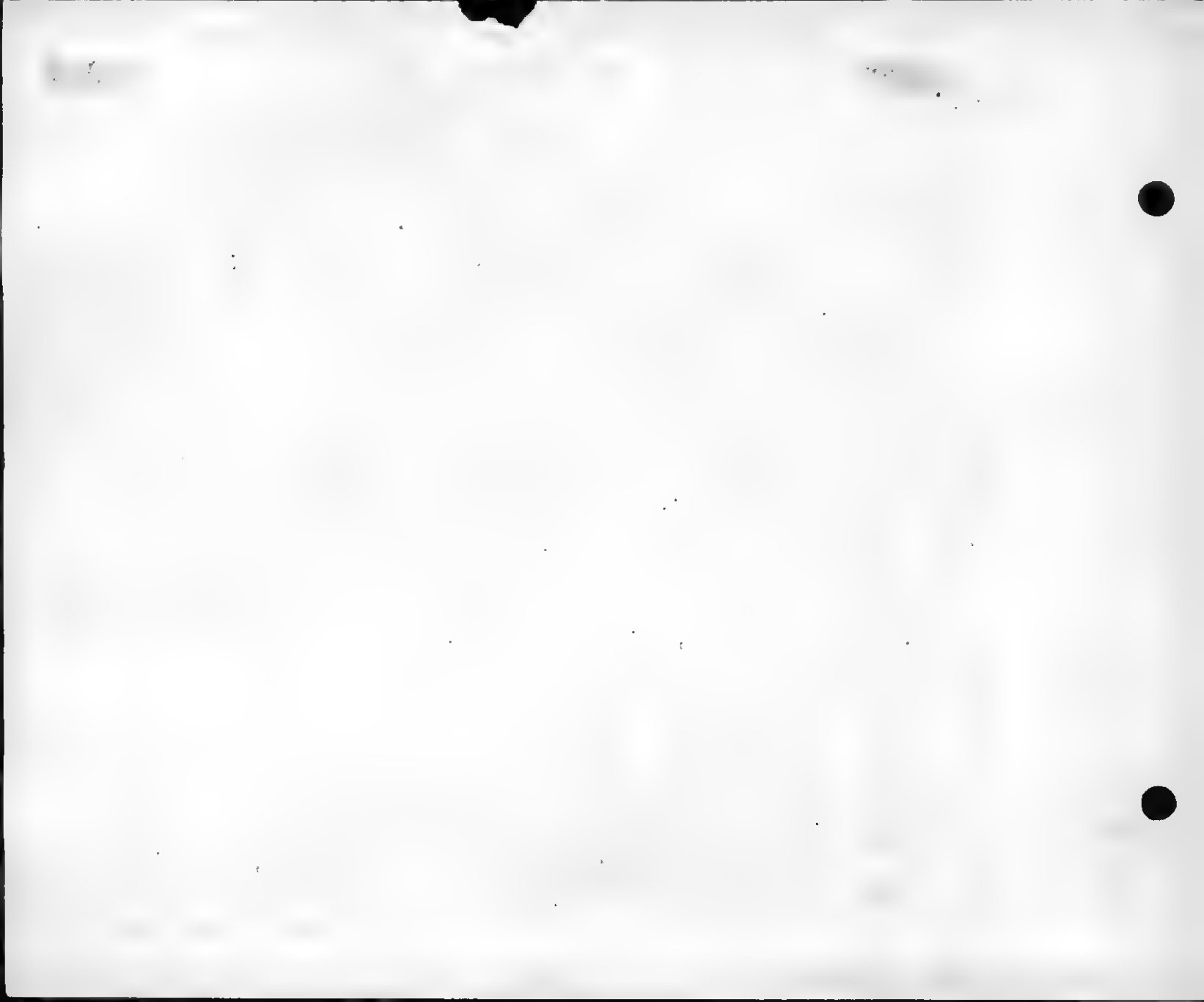
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08256

CERTIFICATE OF DEATH

08244

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 305 S. Eden Street	
3. NAME OF DECEASED (Type or print) First Rose Middle - Last Billitz		4. DATE OF DEATH Month 6 Day 26 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) yrs. 63?		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Elsasser		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Springfield Hospital records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) M. pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that Dr. (this hospital) attended the deceased from 4/14/1958 , to 6/26 , 19 66 , that it (we) last saw the deceased alive on 6/26 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Hassan A. Salih		22b. DATE SIGNED 6/26/66	
22c. PHYSICIAN'S NAME (Type) Hassan A. Salih, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/30/66	23c. NAME OF CEMETERY OR CREMATORY mt Carmel	23d. LOCATION (City or town) (County) (State) Balta, Ind
24. FUNERAL DIRECTOR Sylvan S. Linsamson		25a. REC'D BY REGISTRAR DATE JUL 5 1966	
ADDRESS 3319 Olympia Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08257

CERTIFICATE OF DEATH

08245

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>43 Yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Co. General Hospt.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ERMA JENNINGS</u> First <u>BONSACK</u> Middle Last				4. DATE OF DEATH <u>JUNE 28</u> 19 <u>66</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 20, 1897</u> 68 yrs	
9. AGE (In years last birthday) <u>68</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Bopst</u>				14. MOTHER'S MAIDEN NAME <u>ANNA MARY Brunner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-28-8380</u>		17. INFORMANT <u>Mr. J. Ralph Bonsack</u> Address <u>same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>42</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral Vascular Insufficiency</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 17, 1966</u> , to <u>June 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 28, 1966</u> , and that death occurred at <u>1:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S HARSHEY</u>				22d. ADDRESS <u>8 Carver St. - Westminster, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>		23d. LOCATION (City or Town) (County) (State) <u>Rural Westminster, Md</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr. Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>JUN 30 1966</u>							

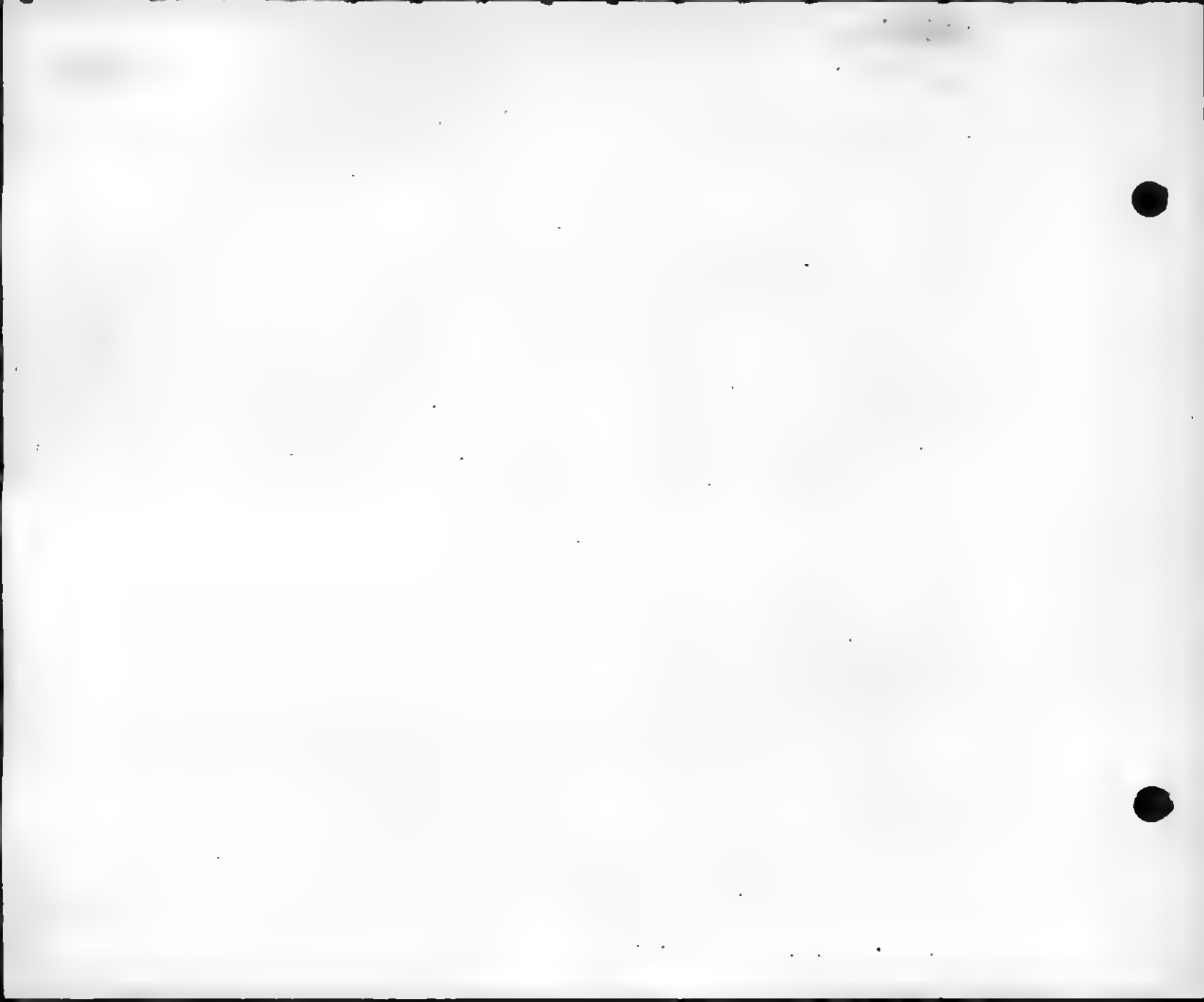
3.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08255 Carroll						08246					
1. PLACE OF DEATH a. COUNTY Carroll						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY Baths.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Manchester, Md.				c. LENGTH OF STAY IN 1b 7 weeks 2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lower Buckhyns Rd, Hampstead, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Longview Nursing Home						d. STREET ADDRESS 128 N. Main St, Manchester, Md.					
3. NAME OF DECEASED (Type or print) Joseph Bosley						4. DATE OF DEATH Month Day Year 6-29-66 19					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1891		9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cockeysville, Md. Balt. Co.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas C. Bosley						14. MOTHER'S MAIDEN NAME Alice Roberta Sanders					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 212-32-4283		17. INFORMANT Joseph Bosley Jr. Son, Hampstead, Md.				Address Lower Buckhyns Rd, Hampstead, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Pneumonia - DUE TO (b) CH Prostate - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.U. Infected m.s.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1, 1966 to 6/29, 1966, that (II) (we) last saw the deceased alive on 6/29, 1966, and that death occurred at 3:45 PM, from the causes and on the date stated above.											
22a. SIGNATURE C. H. Houghton						22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) C. H. Houghton						22d. ADDRESS Greenmount Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/2/66		23c. NAME OF CEMETERY OR CREMATORY Bosley's Cemetery		23d. LOCATION (City, town or county) (State) Sparks Md.			
24. FUNERAL DIRECTOR Tipton - Elvira						ADDRESS Hampstead, Md		25a. REC'D BY REGISTRAR DATE JUL 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

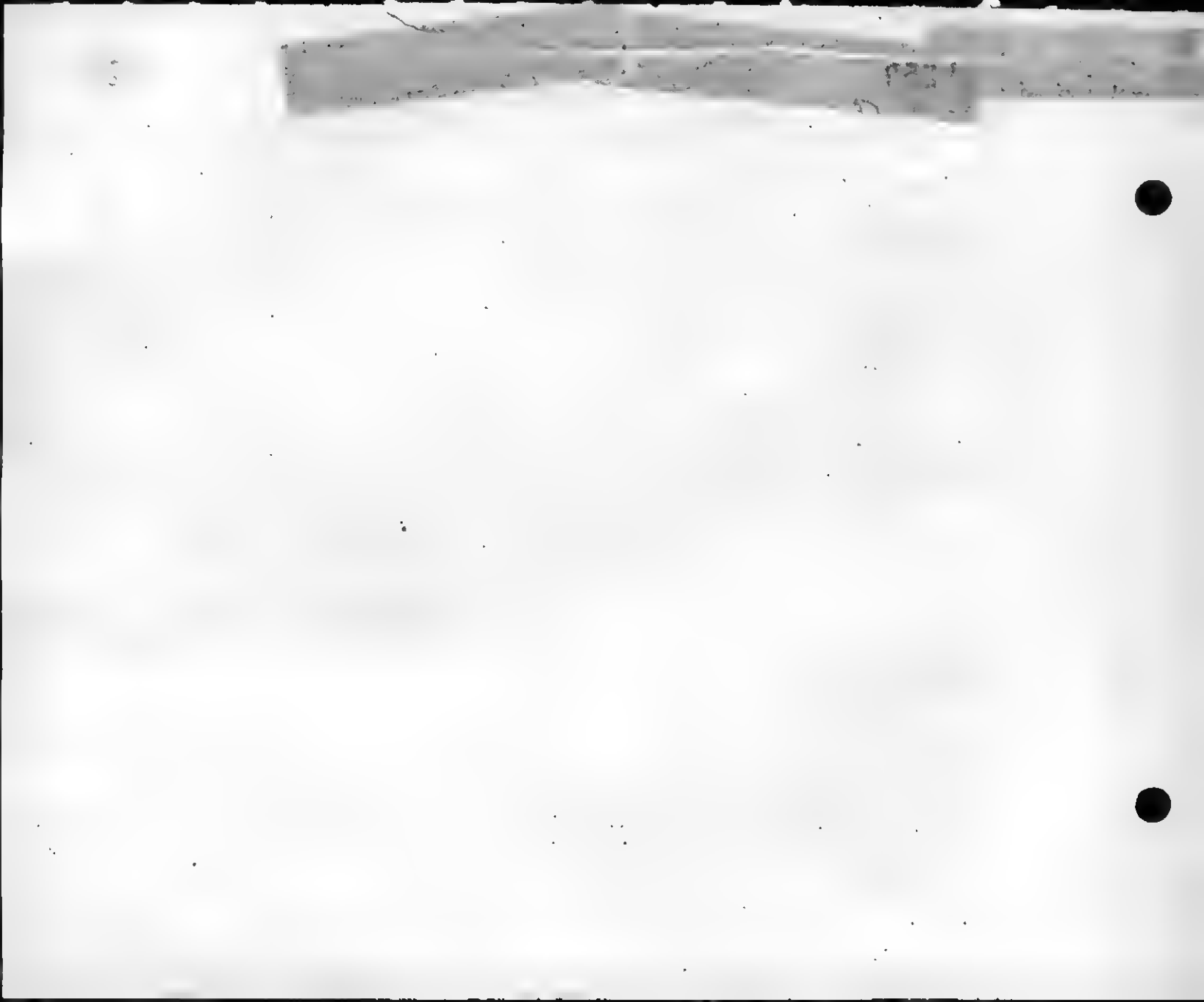
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

08247

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Sykesville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>Years</u>		d. STREET ADDRESS <u>Liberty Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE EDNA BURTON</u> First Middle Last		4. DATE OF DEATH <u>June 28 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1892</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. fc</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>Orpha Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mr. Richard Burton - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u> DUE TO (b) <u>Arterio-Sclerotic C.V. Disease</u> DUE TO (c) <u>Unborn</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Maurice C. Porterfield</u> EXAMINER'S NAME (Type) <u>MAURICE C. PORTERFIELD</u>		22. DATE SIGNED <u>6-28-66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Hampstead, Carroll Co, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-30-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

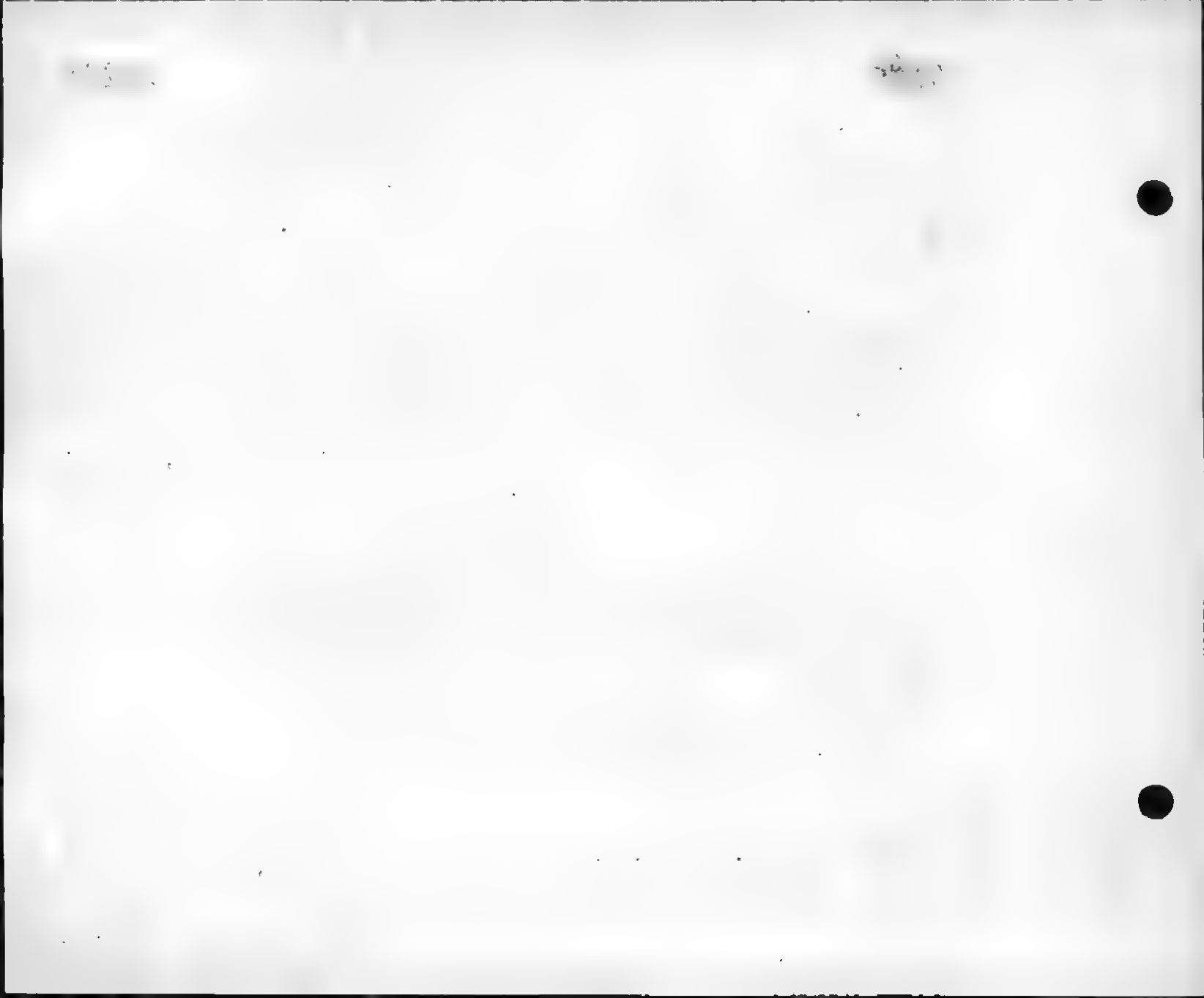
CERTIFICATE OF DEATH

08260

08248

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN 1b 2mo. 6days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived if institut an Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2803 St. Paul St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bessie (NMN) Call 5. SEX female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/5/02 9. AGE (In years last birthday) 64 yrs IF UNDER 1 YEAR Months Days Hours Min.				4. DATE OF DEATH Month 6 Day 20 Year 1966			
10a. USUAL OCCUPATION (Give kind of work done during most of workng life even if retired) Registered Nurse 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William T. Johnson 14. MOTHER'S MAIDEN NAME Frances Fasenbaker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 213-46-1628 17. INFORMANT Address Springfield Hospital records, Sykesville				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO (b) Decubitus ulcers DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome with circulatory disorder (CVA) with psychotic reaction and residual schizophrenia. 19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/14/1966 to 6/20/1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6/20/1966 , and that death occurred at 6:05 PM , from causes and on the date stated above.							
22a. SIGNATURE Ednee J. Reeves 22c. PHYSICIAN'S NAME (Type) Ednee J. Reeves, M.D.				22b. DATE SIGNED 4/21/66 22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-25-66		23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harvey W. Haight				25. REC'D BY REGISTRAR JUN 27 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08262

08249

1. PLACE OF DEATH a. COUNTY Carroll Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Rt. #3 Box 136	
c. LENGTH OF STAY IN 1b 0yr. 2mo. 15da.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) Elbert (NMN) Carroll, Sr		4. DATE OF DEATH Month 6 Day 24 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-11-74
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 6 Days 24 Hours 19 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Carroll		14. MOTHER'S MAIDEN NAME Hanna -- (Carroll)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO 219-10-3240	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 1200 DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) Senile brain disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 5 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with cerebral arteriosclerosis without qualifying phrase.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. 79		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) --	
21. I certify that (a) (this hospital) attended the deceased from 4-9- , 19 66 to 6-24 , 19 66 , that (b) (we) last saw the deceased alive on 6-24 , 19 66 , and that death occurred at 9 A. M, from causes and on the date stated above.			
22a. SIGNATURE Moises Sucholeiki		22b. DATE SIGNED 6-24-66	
22c. PHYSICIAN'S NAME (Type) Moises Sucholeiki, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-27-66	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City or Town) (County) (State) Cecilton, Md.
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR DATE JUN 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

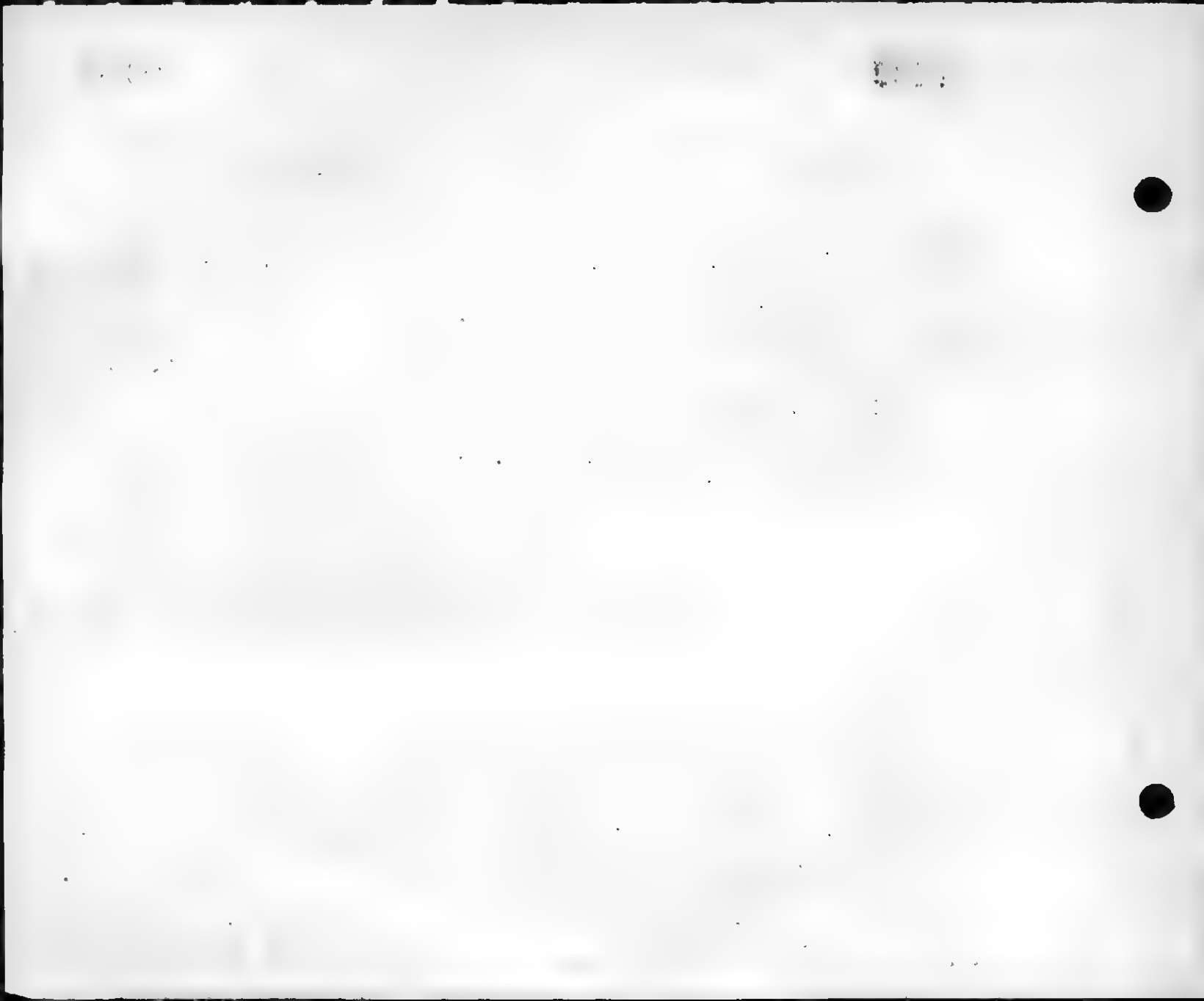
1
FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00262

08250

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ruby First IDA Middle CROUSE Last		4. DATE OF DEATH June 17 Month 19 Day 66 Year	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1890
9a. AGE (In years last birthday) 76 yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson L. Crouse		14. MOTHER'S MAIDEN NAME Carrie Ruby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-46-8015	
17. INFORMANT Mrs. Robert Angell, Taneytown, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4201 Coronary Infarction DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Maurice C. Porterfield EXAMINER'S NAME (Type) Maurice C. Porterfield		22. DATE SIGNED 6-17-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hampstead, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 20, 1966	
23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Taneytown, Maryland	
24. FUNERAL DIRECTOR John H. Skiles C.O. Fuss & Son (John H. Skiles) Taneytown, Md.		25a. REC'D BY REGISTRAR JUN 20 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

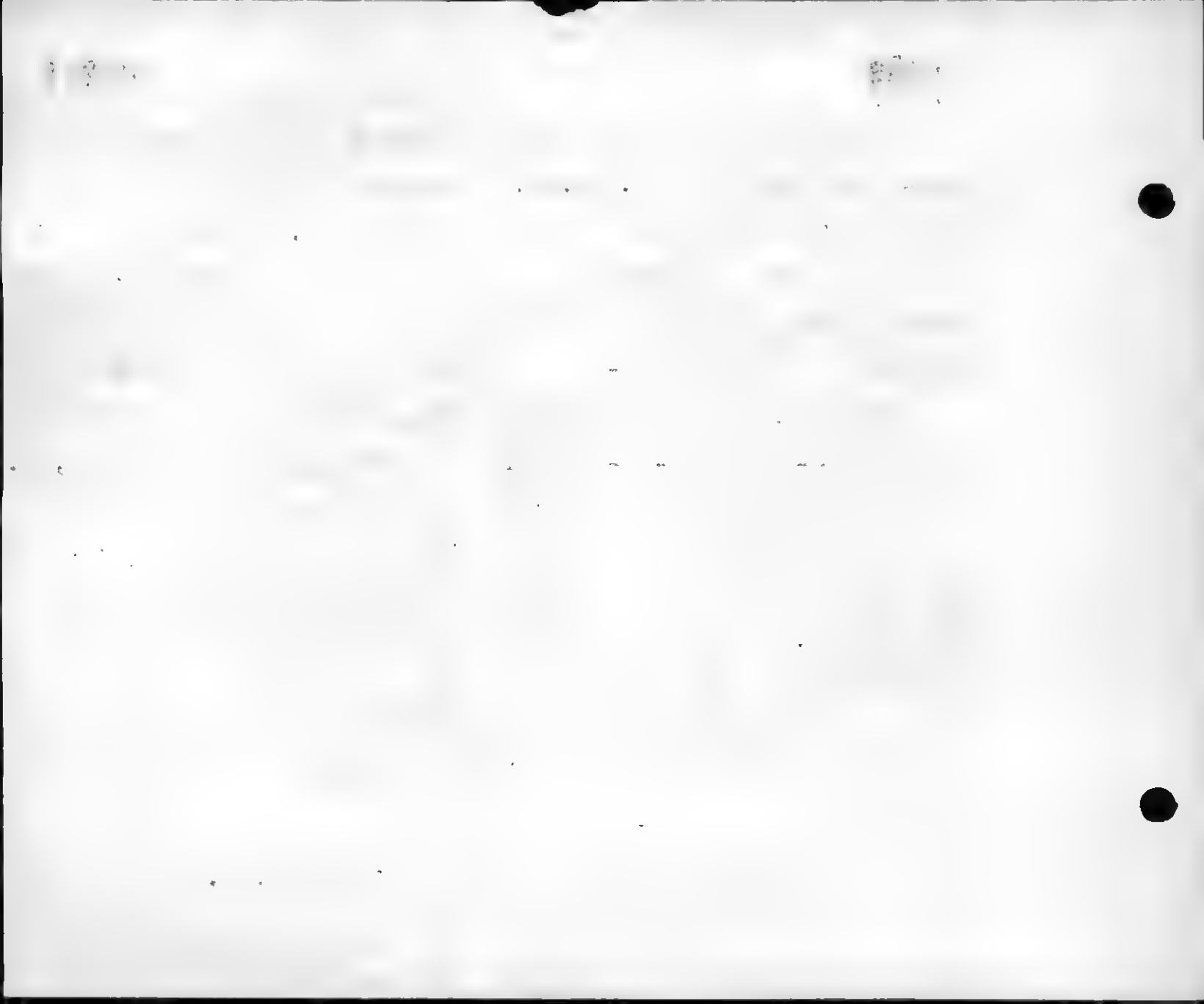
08263

08251

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegheny ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland -01-2	
c. LENGTH OF STAY IN 1b 2y. 10m. 2d.		d. STREET ADDRESS 333 Central Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last May Blanche Curry		4 DATE OF DEATH Month Day Year June 25, 1966	
5 SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1985
9. AGE (in years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ross		14. MOTHER'S MAIDEN NAME Ervin, Martha	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Springfield Hospital records, Sykesville Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO ARTERIOSCLEROSIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated with cerebral arteriosclerosis with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 1 ymo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 4/8/23 , 19 63 , to 6/25 , 19 66 , that (X) (we) last saw the deceased alive on 6/25 , 19 66 , and that death occurred on 11:45 AM from causes and on the date stated above			
22a. SIGNATURE Dr. B. D. Byrd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. B. D. BYRD		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF June 28, 1966	23c. NAME OF CEMETERY OR CREMATORY Ant. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Joseph H. Russ 2222 W. North Ave		25a. REC'D BY REGISTRAR JUN 29 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

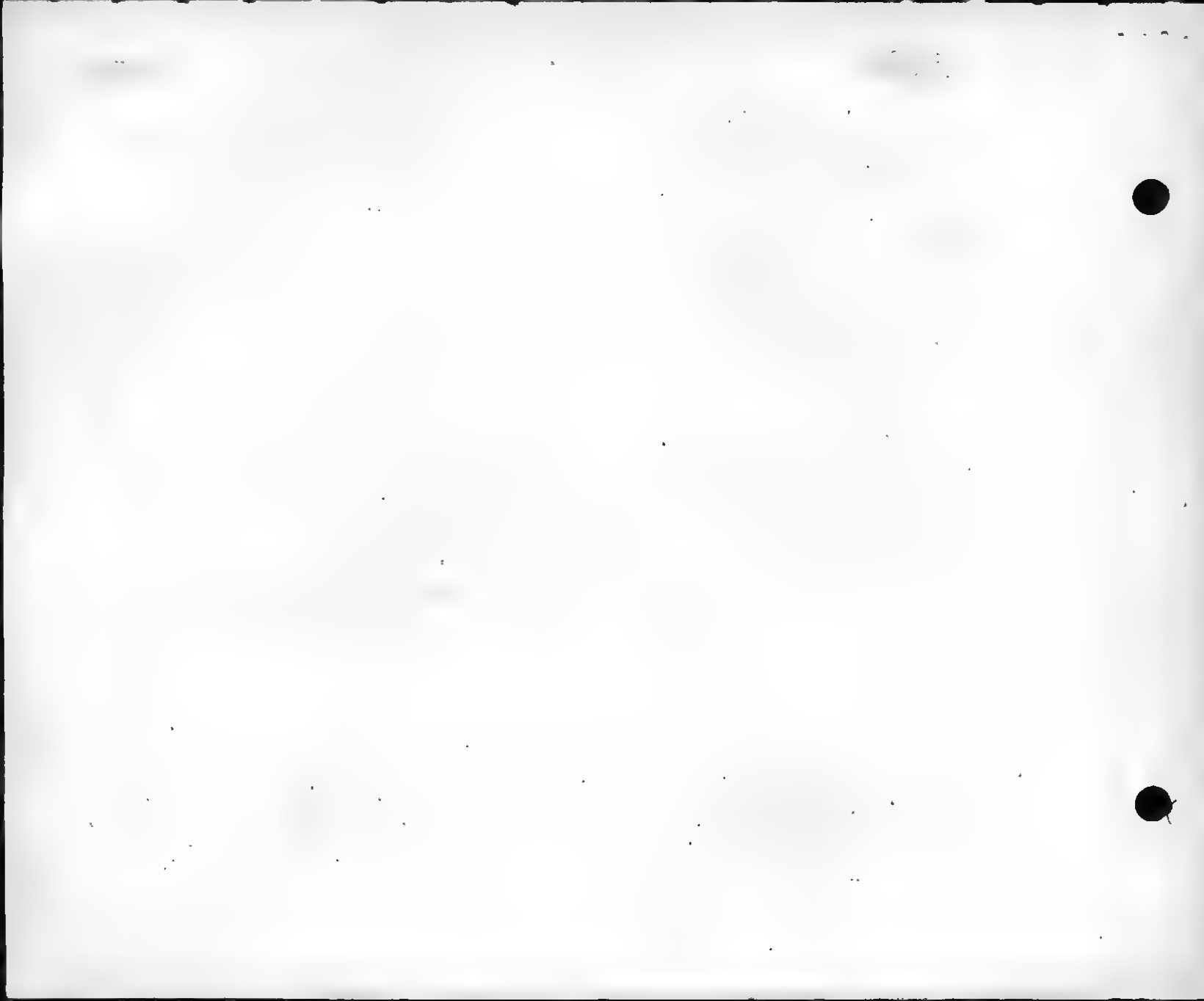
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.




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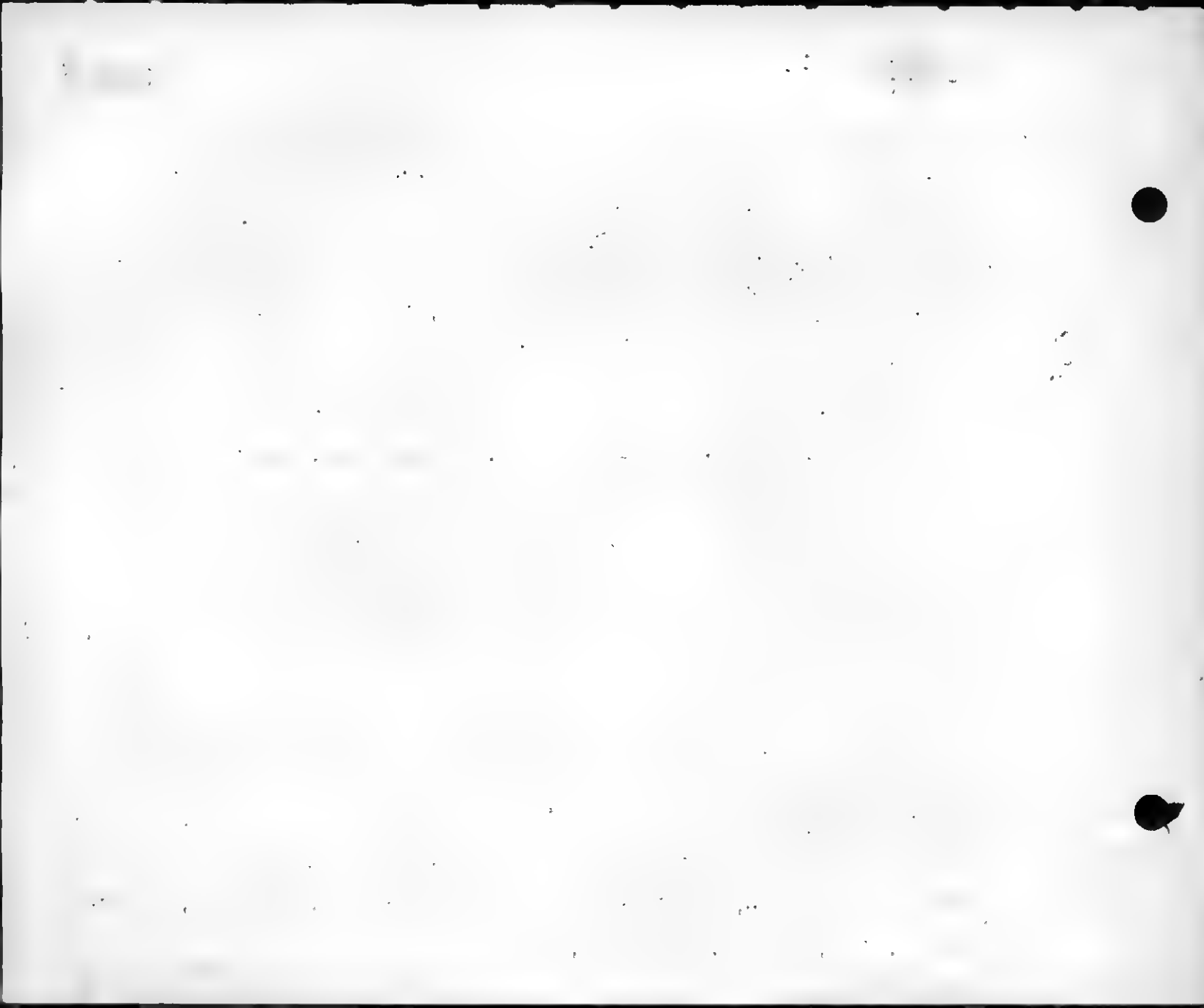
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																			
1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodhull</i>		c. LENGTH OF STAY IN ID <i>8 mo</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Baltimore</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>WAB/D/1617 / Baltimore 17</i>									
3. NAME OF DECEASED (Type or print) <i>Golden Age Sweet Home</i>						4. STREET ADDRESS <i>1802 Eutaw Pl.</i>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1966</i>									
7. SEX <i>Female</i>		8. COLOR OR RACE <i>White</i>		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		10. DATE OF BIRTH <i>11-25-00</i>		11. AGE (In years) <i>65</i> yrs. <table border="1"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.					12. IF UNDER 1 YEAR IF UNDER 24 HRS.	
Months	Days	Hours	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (County & State, or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>MD</i>		13. FATHER'S NAME <i>UNKNOWN</i>									
14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-20-8720</i>		17. INFORMANT <i>Guest Home Records</i>		18. ADDRESS									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concurrent Cardiac Involvement</i> (b) <i>Chr. Myocarditis</i> (c) <i>Hypertrophy of Left Ventricle</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
19. INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 12 1963</i> to <i>June 30 1966</i> that (I) (we) last saw the deceased alive on <i>June 29 1966</i> and that death occurred at <i>4:50 PM</i> from the causes and on the date stated above.																			
22a. SIGNATURE <i>W. H. Martin</i>						22b. DATE SIGNED <i>7/6/66</i>		22c. PHYSICIAN'S NAME (Type) <i>W. H. Martin</i>		22d. ADDRESS <i>Westminster Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>7-2-66</i>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <i>MORELAND MEMORIAL</i>				23d. LOCATION (City, town or county) (State) <i>BALTO MD</i>							
24. FUNERAL DIRECTOR <i>C. F. Evans + Son</i>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>JUL 5 1966</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The  requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08265		08253									
1. PLACE OF DEATH a. COUNTY <u>Woodbine</u> <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R.F.D. LAUREL</u> <u>1.3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Trust Home</u>				d. STREET ADDRESS <u>1600 Scaggsville Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First LILLIAN Middle MERZ Last DEAN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1966</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1898</u>		9. AGE (in years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER W. JONES</u>						14. MOTHER'S MAIDEN NAME <u>FLORENCE E. LOWE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-30-8559</u>		17. INFORMANT <u>Mrs. Lillian Huber, same as #2</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>Parkinson Disease</u> DUE TO (c) <u>Metabolic Deficiency</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>18 yrs</u> <u>8</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 16, 1965</u> to <u>June 12, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 12, 1966</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>H. H. Hartman</u>				22b. DATE SIGNED <u>June 13-66</u>				22c. PHYSICIAN'S NAME (Type) <u>H. H. Hartman</u>			
22d. ADDRESS <u>W. H. Hartman</u>				22e. ADDRESS <u>W. H. Hartman</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>June 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist Church</u>		23d. LOCATION (City, town or county) (State) <u>Gen. Eldersburg, Maryland</u>			
24. FUNERAL DIRECTOR <u>Harold S. Wade, 550 Wash. Blvd, Laurel, Maryland</u>						25a. REC'D BY REGISTRAR <u>JUN 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08266

08254

1. PLACE OF DEATH a. COUNTY <i>CARROLL</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CARROLL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN ID <i>2 hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>CARROLL Co. GENERAL Hospital</i>		e. STREET ADDRESS <i>Rte 2 DEER PARK Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Dayid</i> Last <i>DICKERSON</i>		4. DATE OF DEATH Month <i>JUNE</i> Day <i>12</i> Year <i>1966</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 7, 1916</i>
9. AGE (In years last birthday) <i>49</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>12</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TRUCK DRIVER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Wards</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Arthur Dickerson</i>		14. MOTHER'S MAIDEN NAME <i>Millie Jane ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>215-12-1728</i>	
17. INFORMANT <i>Mrs. Lelia May Dickerson</i>		Address <i>Deer Park Rd. Finksburg, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Maurice C. Porterfield</i> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>HANOVER, Md.</i>	
22. DATE SIGNED <i>6-12-66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 15, 66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Mem. Park</i>	23d. LOCATION (City, town or county) (State) <i>Sykesville, Carroll Co.</i>
24. FUNERAL DIRECTOR <i>H. J. Schacht</i>		ADDRESS <i>Owings Mills, Maryland</i>	
25a. REC'D BY REGISTRAR <i>J. Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	
DATE <i>JUN 16 1966</i>			



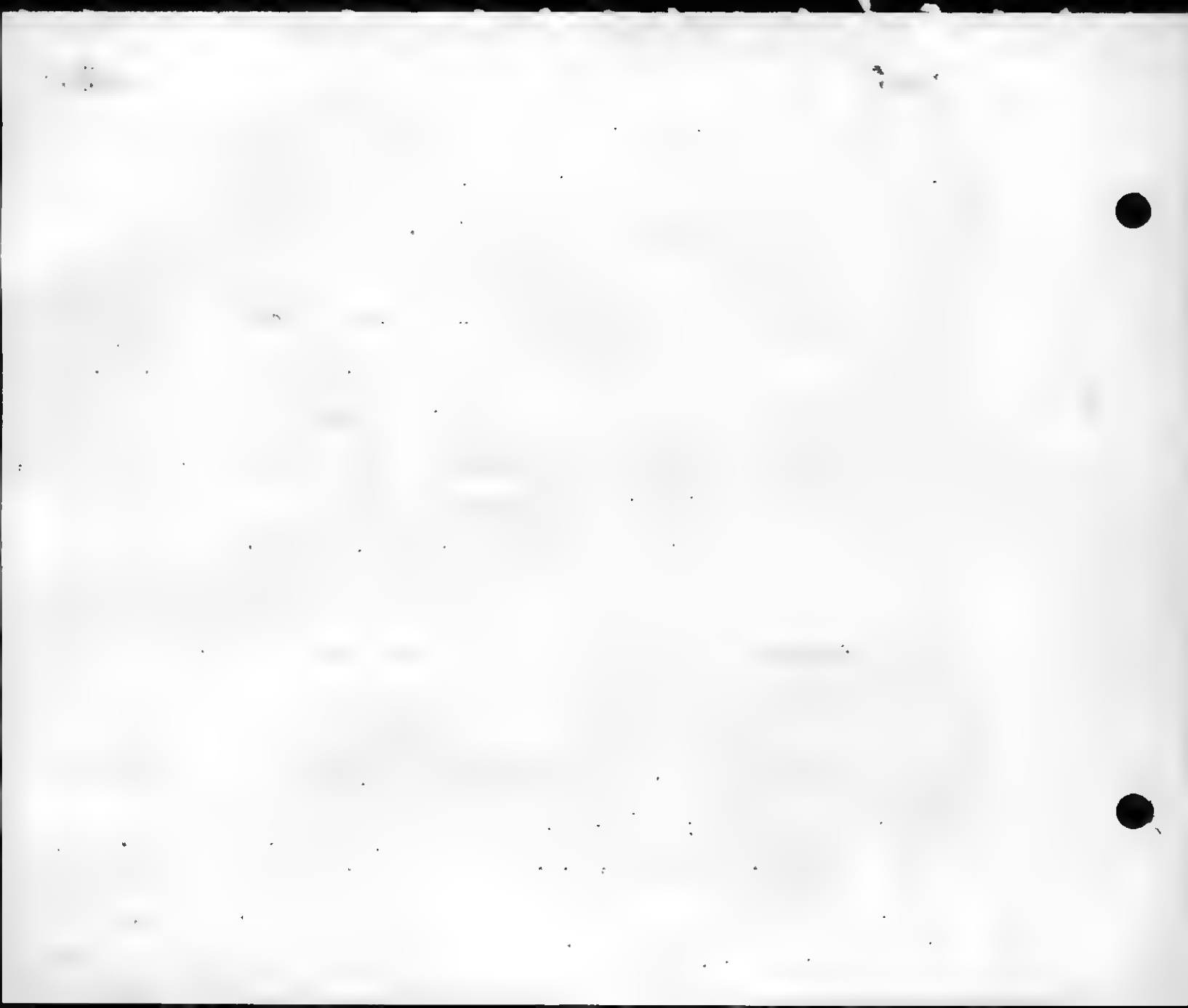
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
08267		08255							
1. PLACE OF DEATH a. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville					b. COUNTY Baltimore City				
c. LENGTH OF STAY IN 1b 3 yr 7mo 23d					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 606 N. Castle Street				
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Mae Dominick					4. DATE OF DEATH Month Day Year 6 28 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 - 1 - 82		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frederick Morgenroth				14. MOTHER'S MAIDEN NAME Cornelia Hahn					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Springfield Hospital records, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4201 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with senile brain disease with psychotic reaction									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from 11-5, 1962, to 6/28, 1966, that (M) (we) last saw the deceased alive on 6/28, 1966, and that death occurred at 7:00 AM from the causes and on the date stated above.									
22a. SIGNATURE Naci N. Buyukunsal, M.D.				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/66		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REC'D BY REGISTRAR DATE JUN 30 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge			

MEDICAL CERTIFICATION



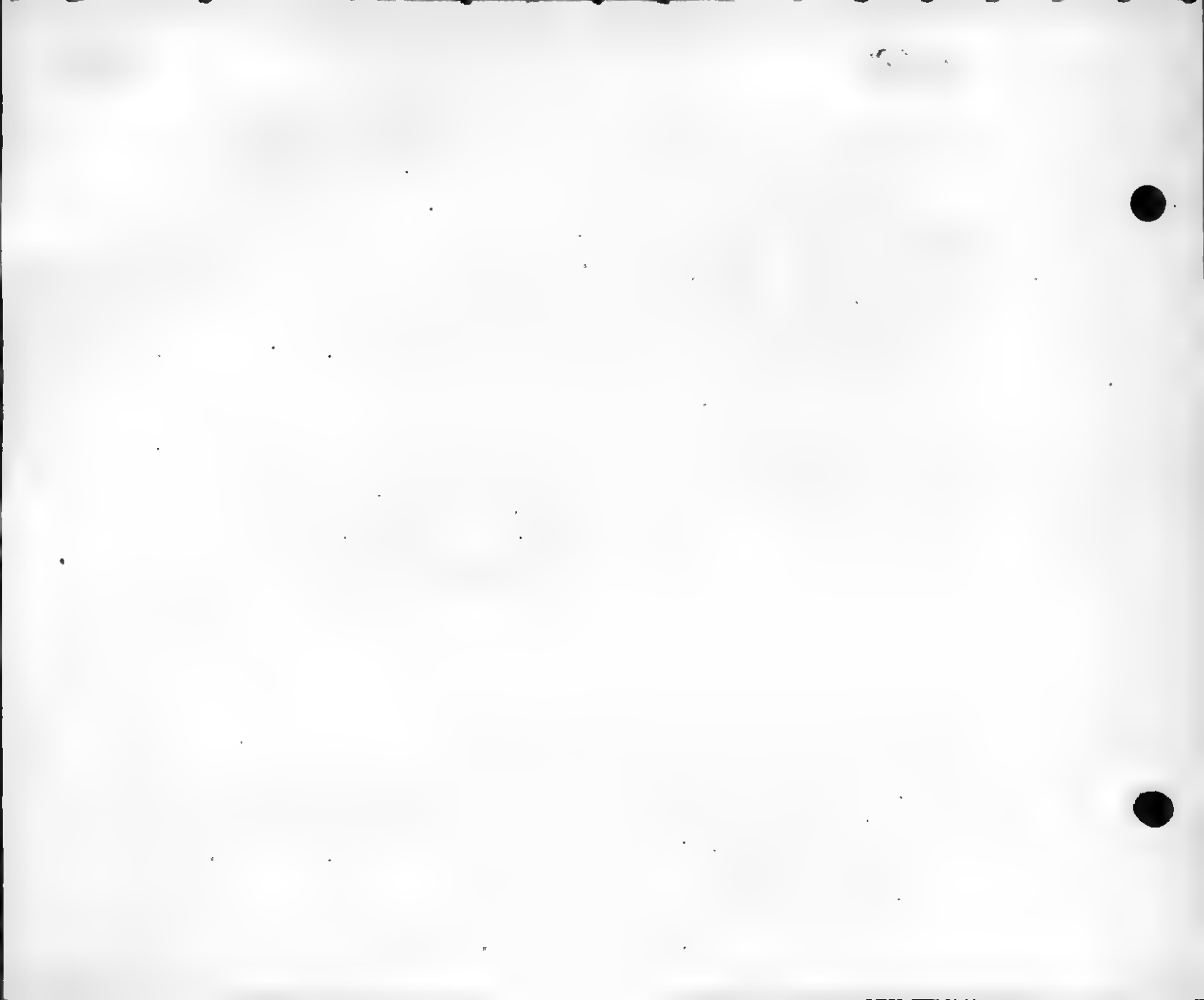
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

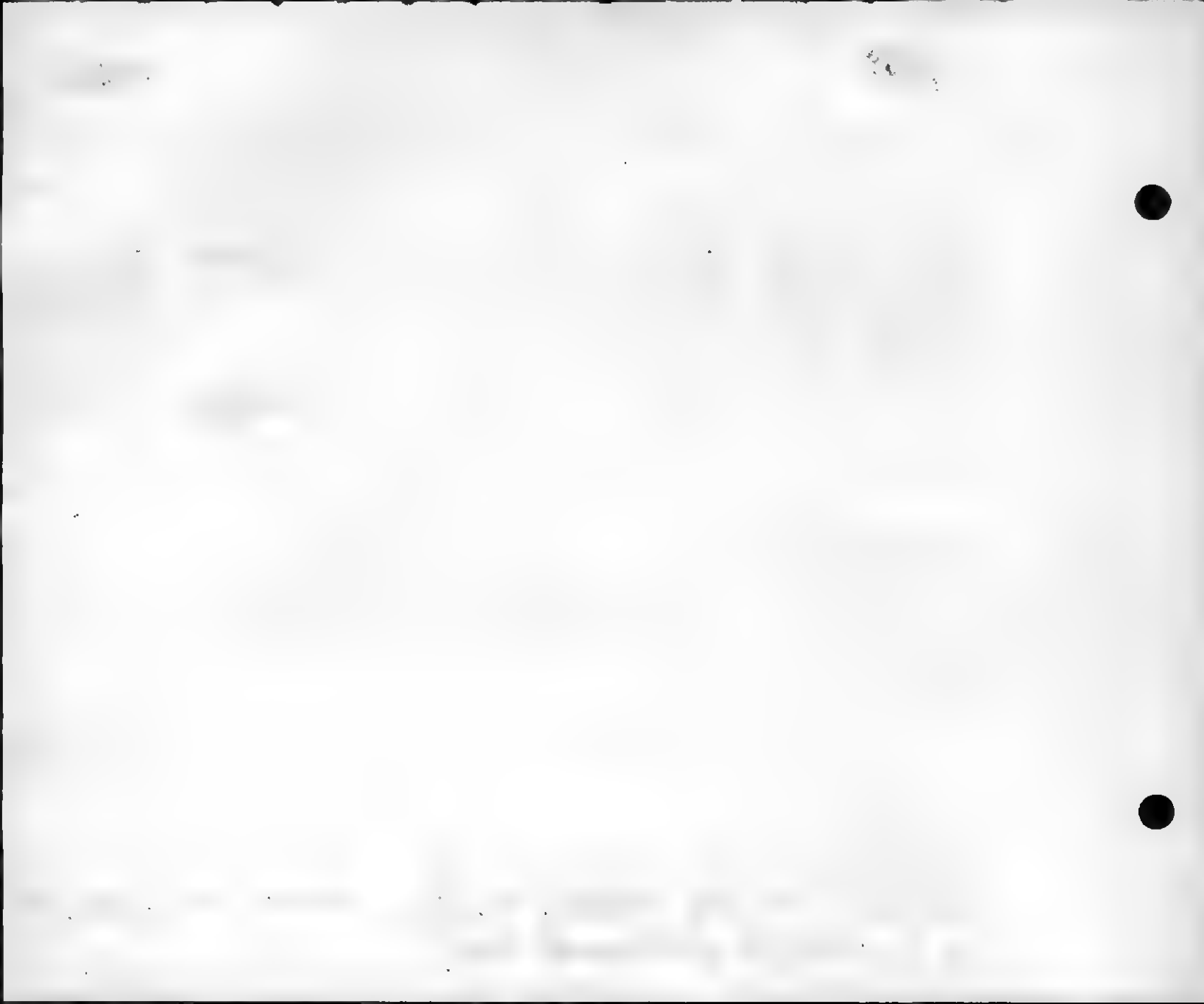
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08268											
08256											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>				c. LENGTH OF STAY IN 1b <u>Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine - Rural</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woodbine - Rural</u>						d. STREET ADDRESS <u>Route 1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u>			First Middle Last <u>D. Duvall</u>			4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1, 1912</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pants Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard Co., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Herbert Crabb</u>						14. MOTHER'S MAIDEN NAME <u>Rosie Wetzel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-07-4822</u>		17. INFORMANT <u>Mr. Willard Duvall Woodbine, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach lining,</u> <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>liver involvement, anemia.</u> DUE TO (c) <u>Cardiac arrest</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1964</u> <u>6-3-66</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> to <u>6-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-3</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>						22d. ADDRESS <u>Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Carroll Co., Md.</u>			
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>						ADDRESS <u>Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
08269						CERTIFICATE OF DEATH						08257	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>7 1/2 N 5 Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles Monroe Ellenberger</u> First Middle Last						4. DATE OF DEATH <u>June 30 1966</u> Month Day Year							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/24/66</u>		9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Ellenberger</u>						14. MOTHER'S MAIDEN NAME <u>Sandra Radzky</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sandra Ellenberger</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity Birth wgt 2 1/4"</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Placenta Previa</u>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>6-24</u> , 19 <u>66</u> , to <u>6-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-29</u> , 19 <u>66</u> , and that death occurred at <u>1:12</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Karl M. Green</u> M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>6/30/66</u>							
22c. PHYSICIAN'S NAME (Type) <u>KARL M. GREEN MD</u>						22d. ADDRESS <u>181 Fairfield Westminster</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Winters Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Burial Westminster, Md.</u>					
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster Md.</u> ADDRESS						24a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE					
						DATE <u>JUL 5 1966</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

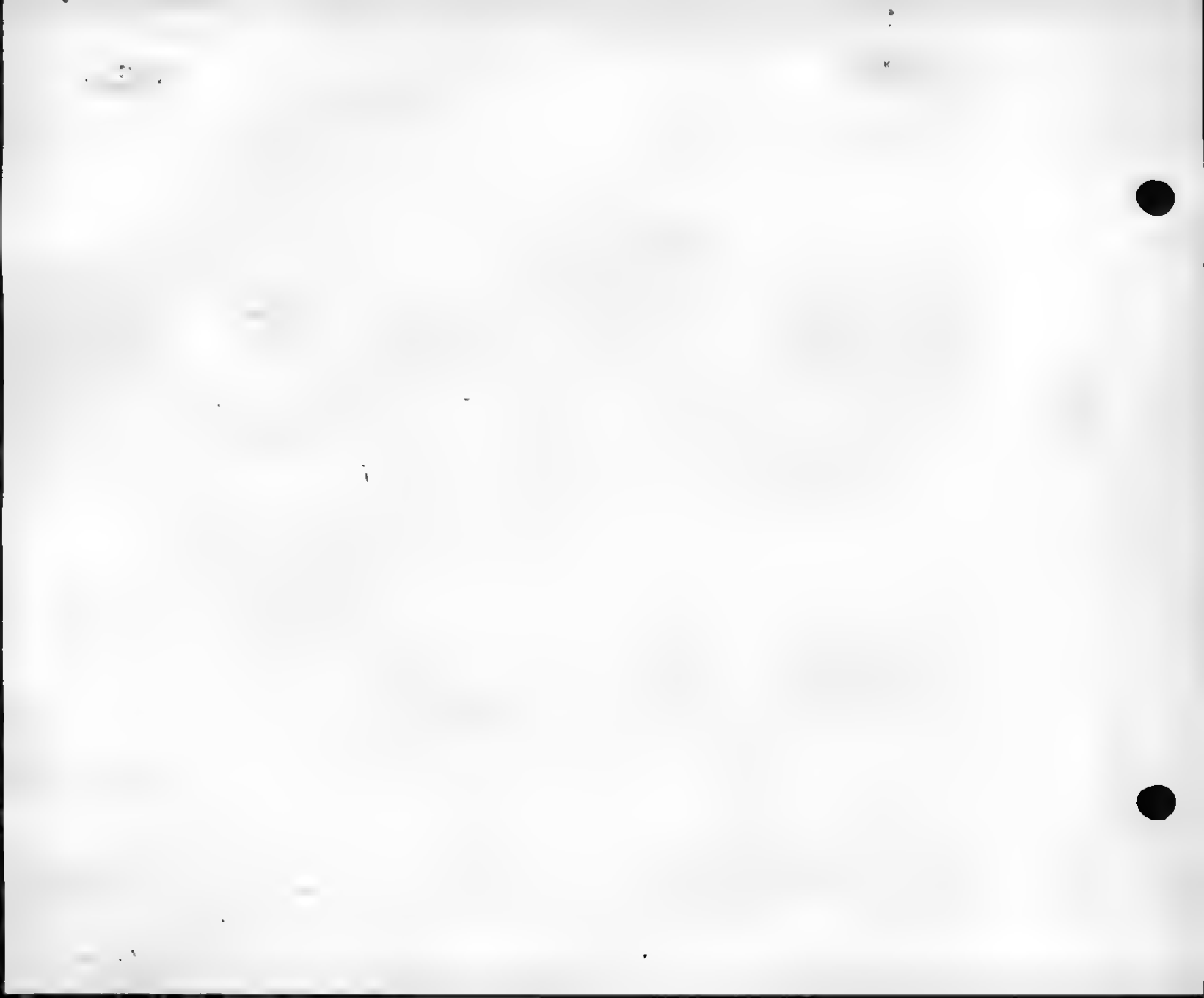
08270

08258

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Rural Lakesville</u>		c. LENGTH OF STAY IN 1b <u>9 mo 15 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1012 Bonaparte Avenue #18</u>			
3. NAME OF DECEASED (Type or print) <u>Daniel James Engelbach</u> First Middle Last				4. DATE OF DEATH <u>June 5 1966</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>12/24/81</u> 9. AGE in years <u>84</u> ¹⁰¹ ₁₁₅		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Jacob Engelbach</u>			14. MOTHER'S MAIDEN NAME <u>Mary Sheehan</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William Engelbach, son, above</u> Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with cerebral arteriosclerosis with</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>65</u> , to <u>6/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/5</u> , 19 <u>66</u> , and that death occurred at <u>10:15 AM</u> on <u>6/5</u> , 19 <u>66</u> , and that death was caused by <u>—</u> on the date stated above.					
22a. SIGNATURE <u>Alberto D. Arengo</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/5/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Alberto D. ARENGO, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u>					
23a. BURIAL, CREMATION, REMOVA (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane #13</u>					
25a. REC'D BY REGISTRAR <u>JUN 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



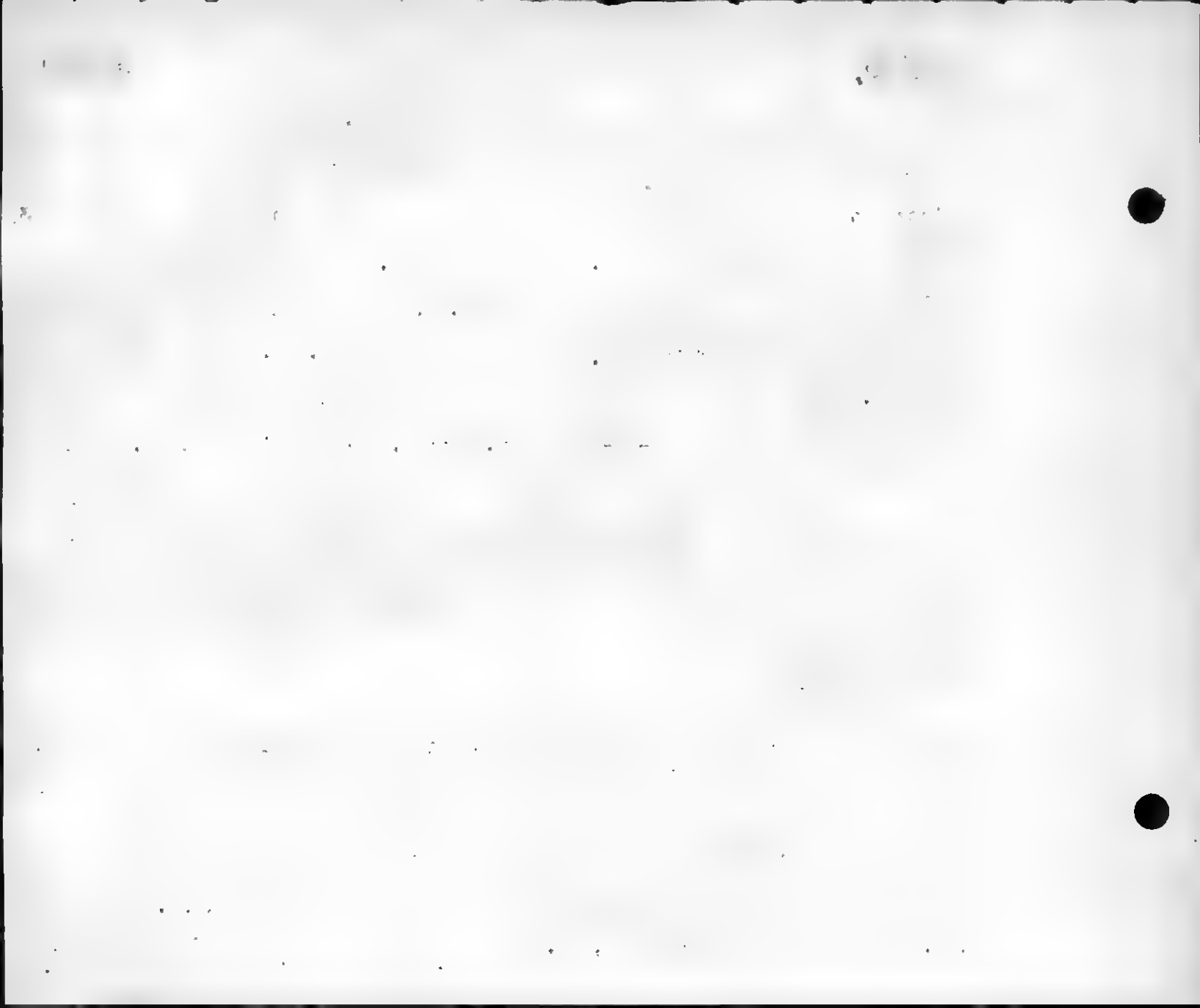
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08271					08259					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Carroll MARYLAND					a. STATE Md. b. COUNTY Carroll					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Finksburg					
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS Bloom Road					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bloom Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
			Oliver	R.	Fair Sr.	June 7, 1966				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 11, 1884		81 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Congoleum-Nairn Inc.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John F. Fair					14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 216-07-3848A		17. INFORMANT Mr. John F. Fair		Address Baltimore, Md. 21224			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Coronary Occlusion										
4201 DUE TO (b) Coronary Insufficiency										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 9-12-61 , 19____, to 6-7-66 , 19____, that (I) (we) last saw the deceased alive on May 19 , 19 66 , and that death occurred at 2 P.M. from the causes and on the date stated above.										
22a. SIGNATURE D. D. Caples					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-8-66			
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.					22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/10/66		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden		23d. LOCATION (City, town or county) (State) Finksburg, Md.			
24. FUNERAL DIRECTOR J. F. Eline & Sons					ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR JUN 10 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. In any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

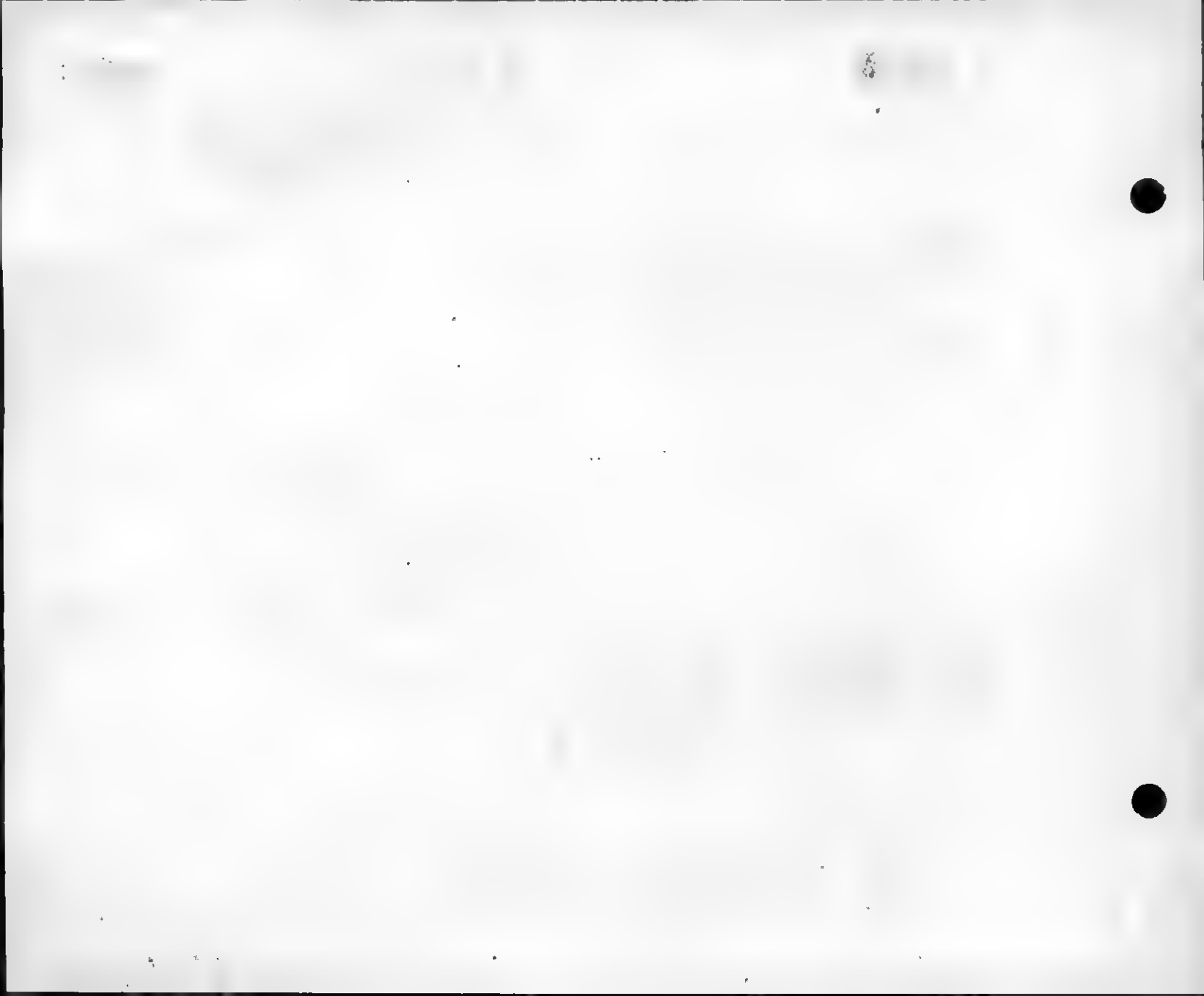
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08272

CERTIFICATE OF DEATH

08250

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - New Windsor		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - New Windsor	
c. LENGTH OF STAY IN b 16 Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		d. STREET ADDRESS Route 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle O. Last Farver		4. DATE OF DEATH Month June Day 16 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1887
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Farver		14. MOTHER'S MAIDEN NAME Jane Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-07-9793	
17. INFORMANT Mrs. Martha S. Farver		Address Sykesville, Md. Route 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V.D. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Severe
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957, 19 to 6/16/66 , that (I) was last saw the deceased alive on 5/29/66 , and that death occurred at 6:30 AM , from causes and on the date stated above			
22a. SIGNATURE M. E. Robertson		22b. DATE SIGNED 6/16/66	
22c. PHYSICIAN'S NAME (Type) M. E. Robertson		22d. ADDRESS New Windsor, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/19/1966	23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery	23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR JUN 20 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08273

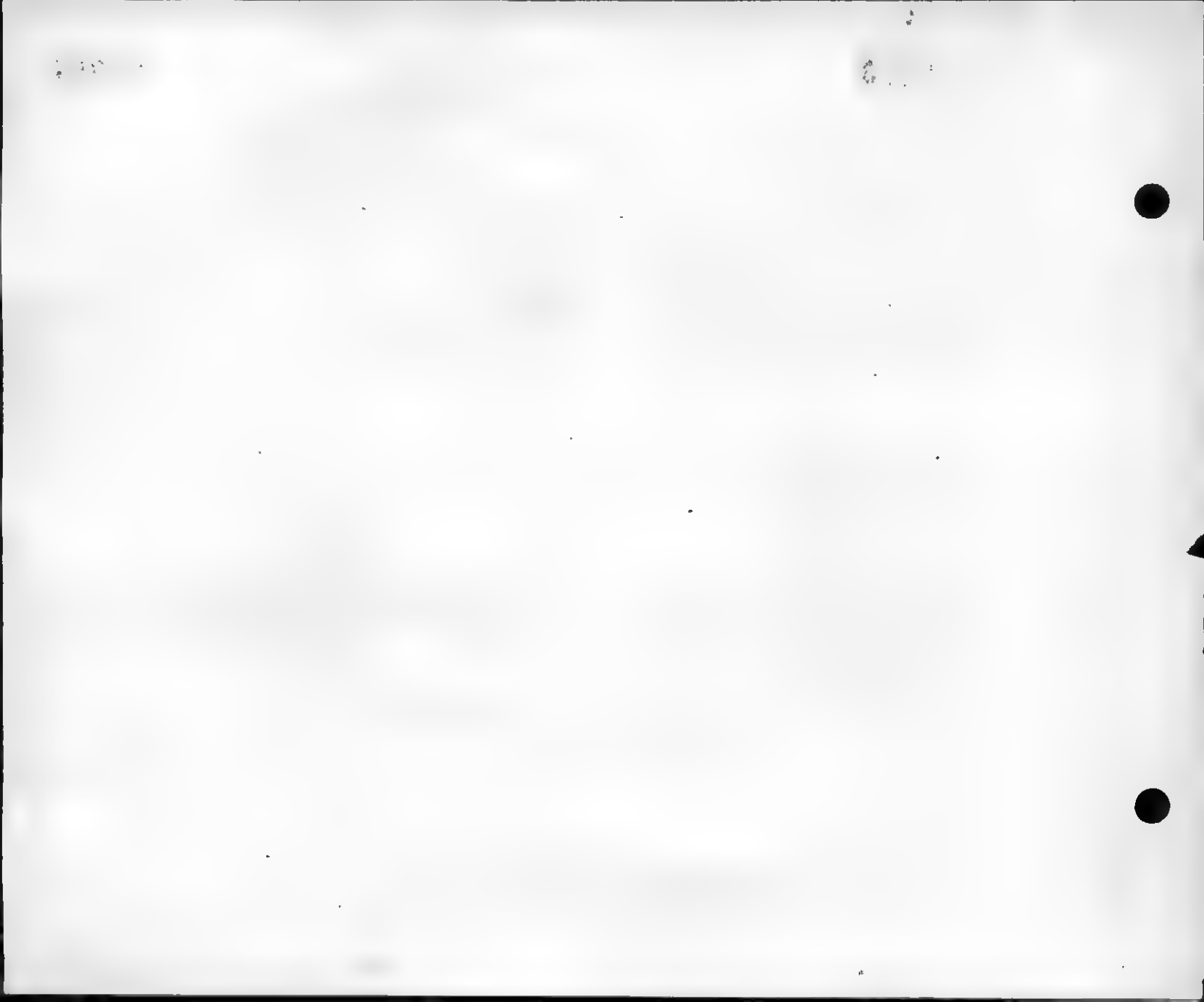
CERTIFICATE OF DEATH

08261

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Wicomico City - 0</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hosp. Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>HESTER RYAN FLOYD</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>72 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Florence Harris</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>317-01-3509</u>	
17. INFORMANT <u>Hospital records</u>		Address <u> </u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Decubitus ulcers - Toxemia</u> 4 1 DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u> </u> (c) <u>Generalized arterio-sclerosis</u> year - <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>C.O.S.S. associated with cerebral arterio-sclerosis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (if (this hospital) attended the deceased from <u>7-27</u> , 19 <u>63</u> , to <u>6-25</u> , 19 <u>66</u> ; that (if (we) last saw the deceased alive on <u>6-25</u> , 19 <u>66</u> , and that death occurred at <u>2:55</u> p.m., from causes and on the date stated above.			
22a. SIGNATURE <u>Suhm Ogden</u>		22b. DATE SIGNED <u>6-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SUHMA OGDEN</u>		22d. ADDRESS <u>Springfield State Hosp. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-29-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR <u>Francis A. Hensley 578 W. Biddle St.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

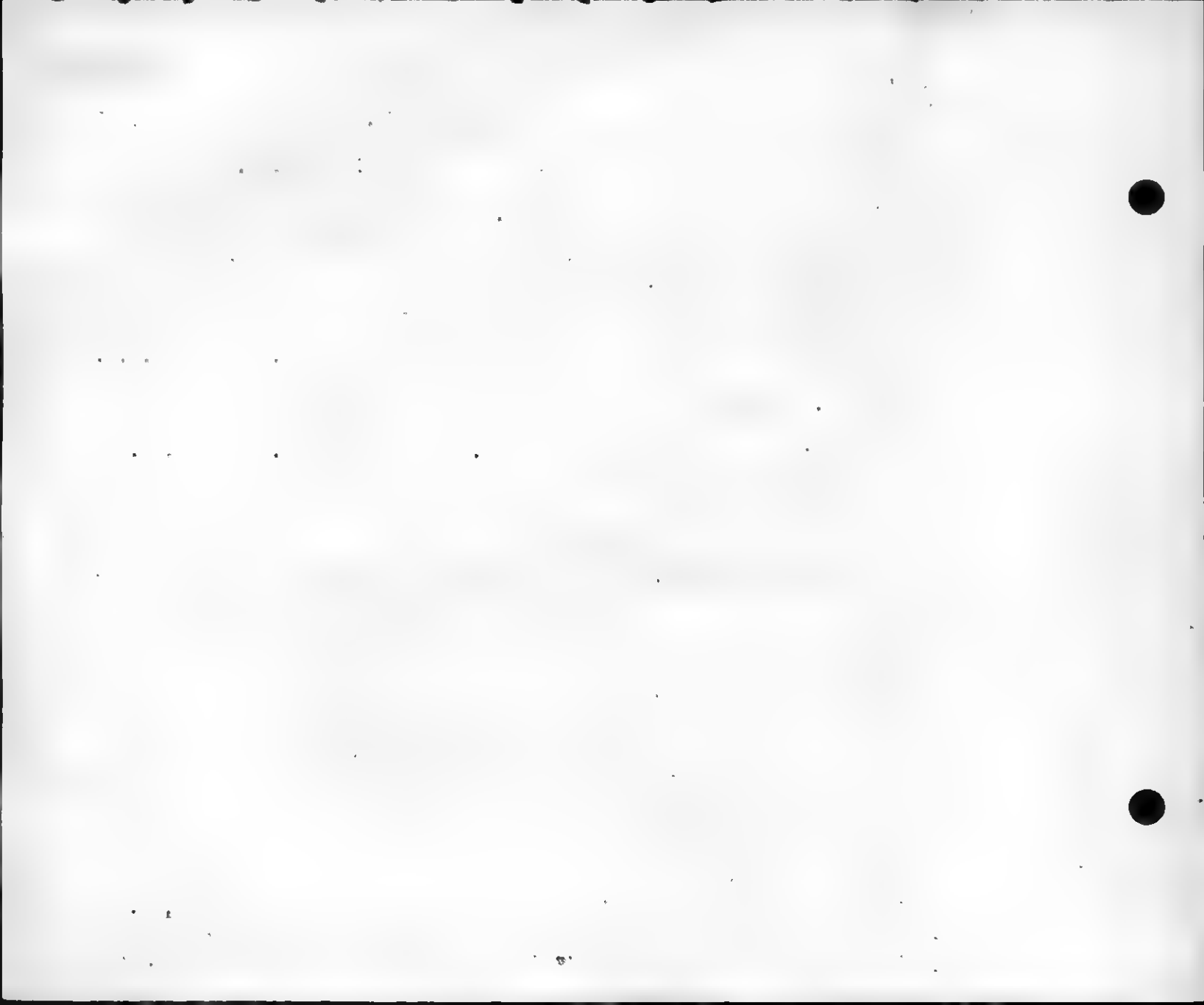
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082774		MARYLAND STATE DEPARTMENT OF HEALTH		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
Item 2 Film G378 6/20/66		Item 9 Film G377 6/16/66		08262	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminister</u>		c. LENGTH OF STAY IN ID <u>8 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Meadow View Nursing Home, Westminister, Md.</u>		e. STREET ADDRESS <u>Route #1</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Greenwall French</u>		4. DATE OF DEATH <u>June 10, 1966</u>		5. AGE (in years last birthday) <u>77 yrs.</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>June 17, 1888</u>		9. AGE (in years last birthday) <u>77 yrs.</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Randallstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph F. Greenwall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anolt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Maureen Lingg, Rt. 1, Dover, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transition</u> DUE TO (b) <u>Dysphagia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cerebro-vascular accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of uterus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>June 3, 1966</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1966</u> , to <u>June 10, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 9, 1966</u> , and that death occurred at <u>6:11 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Julius Chopko</u>		22b. DATE SIGNED <u>6/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chopko</u>		22d. ADDRESS <u>854 W. Green St Westminister Md</u>		22e. M.D. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Pikesville 8, Md.</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville 8, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08275

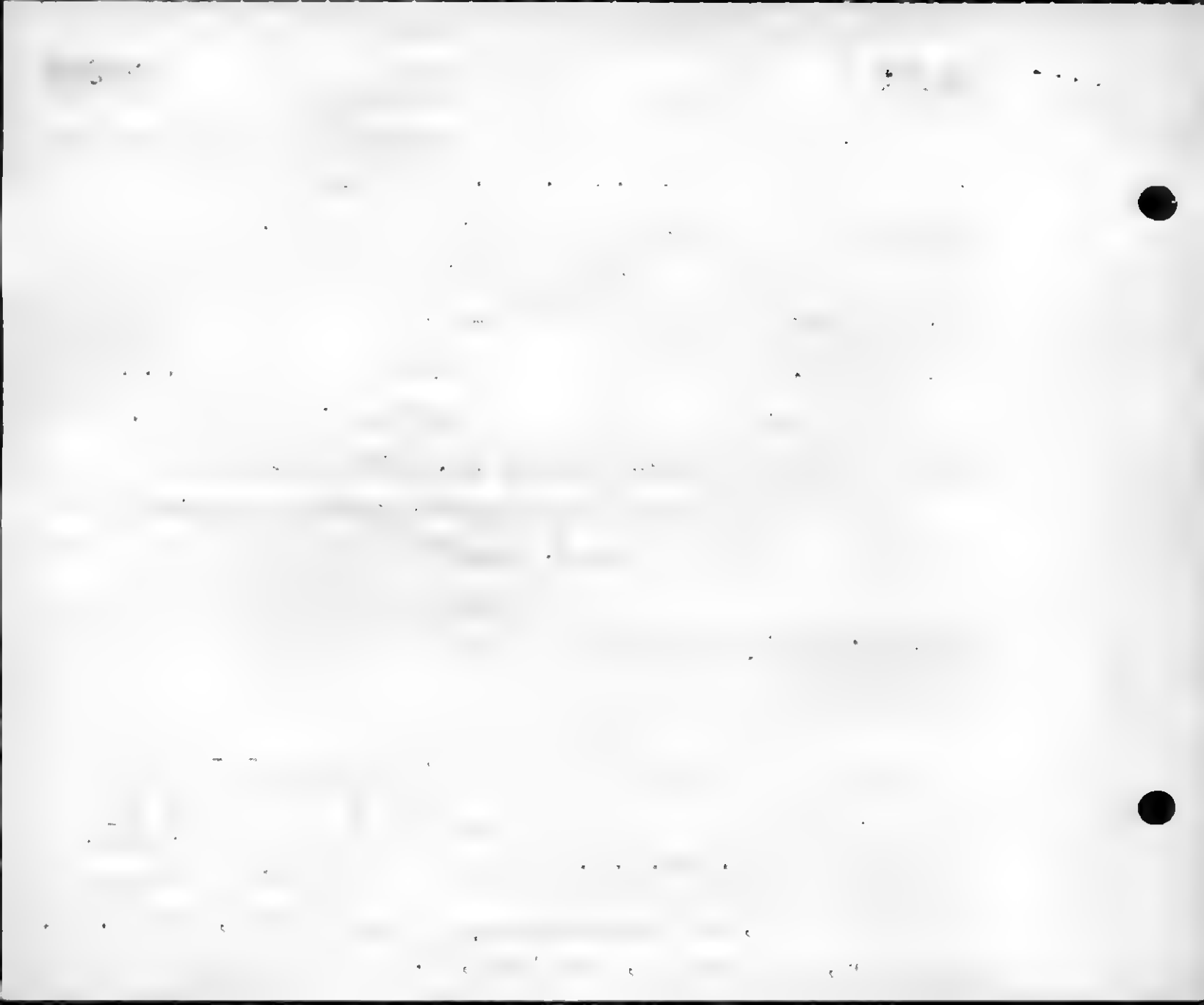
CERTIFICATE OF DEATH

08263

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 11mos. 17dys. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 2910 Woodland Ave.	
3. NAME OF DECEASED (Type or print) First JACOB Middle AARON Last GEORGE		4. DATE OF DEATH Month JUNE Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Paul George		14. MOTHER'S MAIDEN NAME Anna Margaret (last name unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 212-26-6144	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure due to coronary artery insufficiency 4701 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis, right kidney DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MED. CAL. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-13-63 , 19 63 , to 6-30-66 , 19 66 , that (I) (we) last saw the deceased alive on 6-30-66 , 19 66 , and that death occurred at 8:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz M.D.		22b. DATE SIGNED 7-1-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF July 5, 1966	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Sykesville, Balto Co., Md.	
24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd, Randallstown, Md.		25a. REC'D BY REGISTRAR JUL 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08276

CERTIFICATE OF DEATH

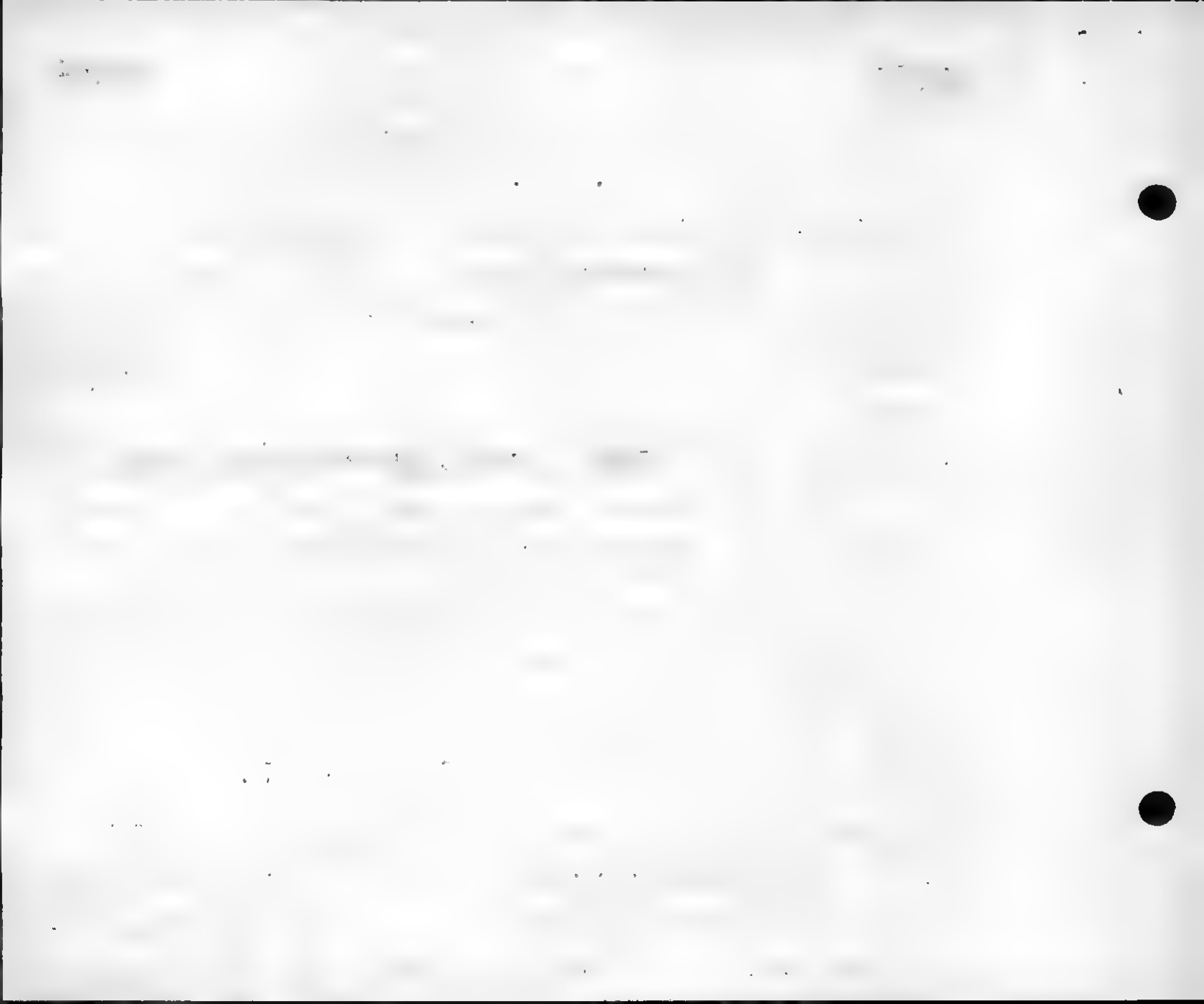
08264

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1mos.17 dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MOLLIE SCHUMACHER GOODMAN		4. DATE OF DEATH Month Day Year June 6 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/89 9. AGE (in years lost birthday) 76 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (County & State or foreign country) Russia
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A. Naturalized.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-2736	
17. INFORMANT MR. MILTON B. EDELSON		Address 1206 FIDELITY BUILDING #7	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, due to protans DUE TO (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work or work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-19-66 , 19 66 , to 6-6-66 , 19 66 , that (I) (we) last saw the deceased alive on 6-6-66 , 19 66 , and that death occurred on 10-4-66 , 19 66 , from causes on and on the date stated above			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 6-6-66	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JUNE 8, 1966	23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM	23d. LOCATION (City or Town) (County) (State) O'DONNELL STREET BALTO., MD
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN		25a. REC'D BY REGISTRAR JUN 9 1966	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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VR A15 (4)
20 M 1/66

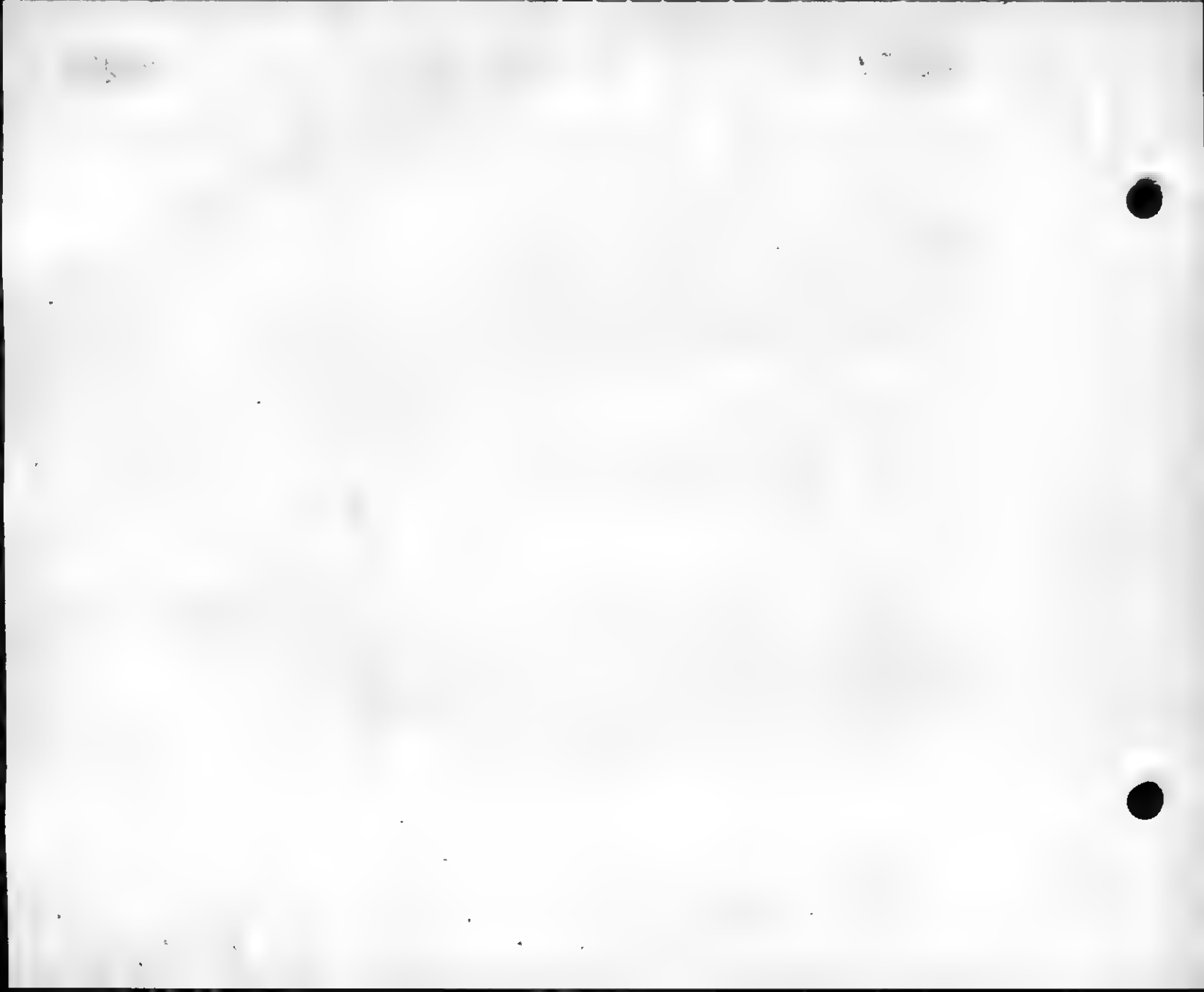


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VR A15 (4)
15M 4-64

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
08277 Item 1d 111m 6377 6/10/66 mh		08265									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD 1</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster RFD 3-1</u> d. STREET ADDRESS <u>(Rural)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Todd</u> Middle <u>Eric</u> Last <u>Greenwood</u>						4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/25/64</u>		9. AGE (In years last birthday) <u>1 10</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u>0</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Honover, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Greenwood</u>						14. MOTHER'S MAIDEN NAME <u>Phyllis McDonald</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Edward Greenwood 3 Md. Westminster</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Hemorrhagic pneumonia</u> 493 X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/9/1</u> , 19 <u>64</u> , to <u>6/4</u> , 19 <u>66</u> , that (I/we) last saw the deceased alive on <u>6/3</u> , 19 <u>66</u> , and that death occurred at <u>1:15</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>W H Foard</u>						22b. DATE SIGNED <u>6/4/66</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H Foard. M.D.</u>			
22d. ADDRESS <u>Manchester, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Finksburg, Md.</u>			
24. FUNERAL DIRECTOR <u>Tipton-Eline</u>						25a. REC'D BY REGISTRAR <u>WUN 8</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH

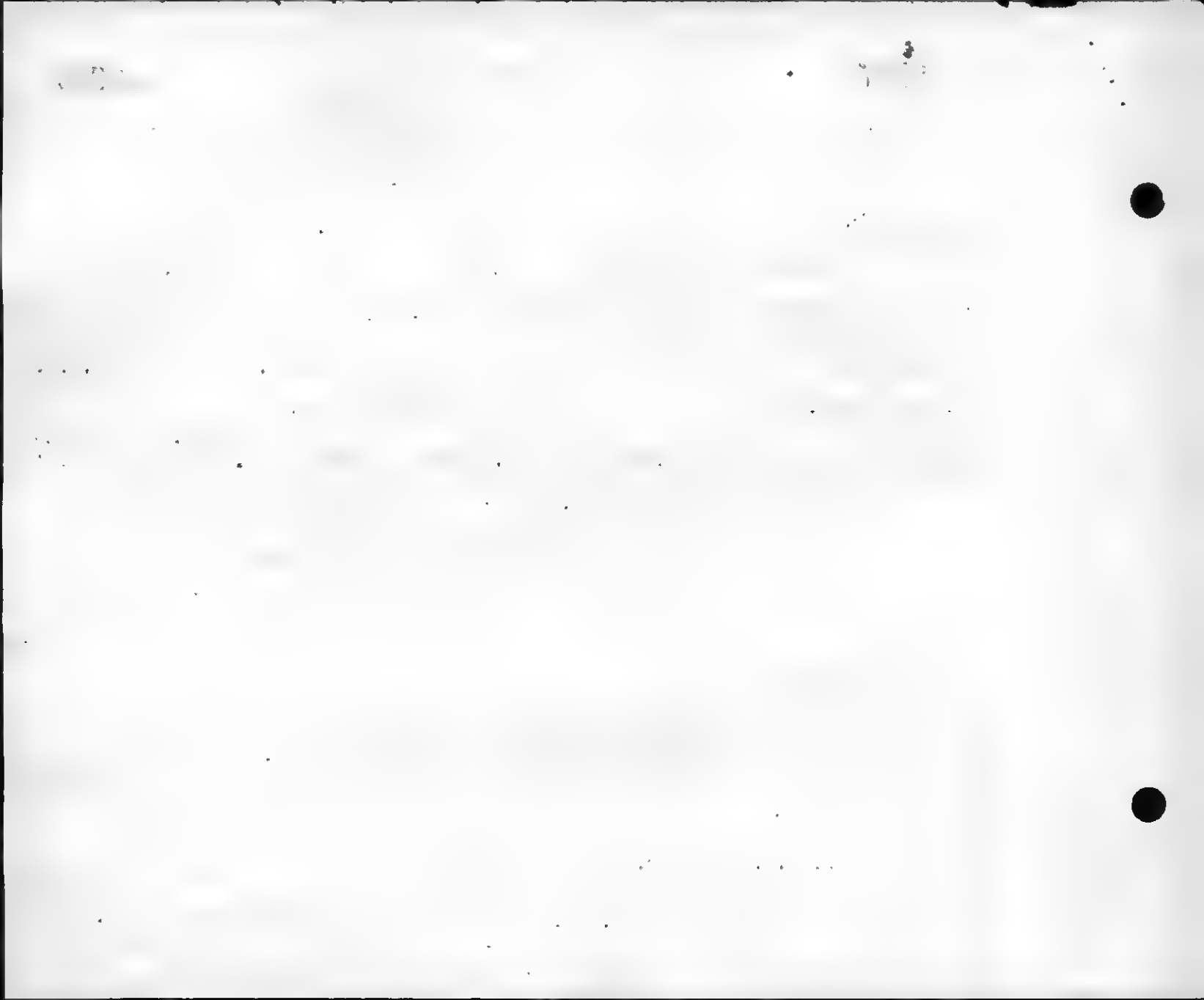
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08278

CERTIFICATE OF DEATH

08267

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 32 Marvin Ave				d. STREET ADDRESS 32 Marvin Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Amelia Louise Henritz				4. DATE OF DEATH Month June Day 26 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1896		9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Randallstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Spealman				14. MOTHER'S MAIDEN NAME Helena Frank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Harry N. Henritz Rte. 4 Box 213			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DEHYDRATION & STARVATION DUE TO (b) METASTATIC CARCINOMATOSIS DUE TO (c) CARCINOMA HEAD PANCREAS				INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 Mo 2 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1964 to 6-26 , 19 66 that (I) (we) last saw the deceased alive on 6-25 , 19 66 , and that death occurred at 12:30 AM , from causes and on the date stated above.							
22a. SIGNATURE R.V. Houck Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-27-66	
22c. PHYSICIAN'S NAME (Type) Dr. R.V. Houck Jr.				22d. ADDRESS SYKESVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City or Town) (County) (State) Randallstown Balto. Md	
24. FUNERAL DIRECTOR Living Byrne				25a. REC'D BY REGISTRAR DATE JUN 30 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08279

08268

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - Rural	
c. LENGTH OF STAY IN 1b 66 years		d. STREET ADDRESS Route 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle A. Last Hentzman		4. DATE OF DEATH Month June Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1896
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8	11. IF UNDER 24 HRS Hours 19 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Hentzman		14. MOTHER'S MAIDEN NAME Katharina Kohler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-8126	
17. INFORMANT Mrs. Mildred L. Hentzman		Address Sykesville, Md. Route 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Unknown.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/8/66 19 66 , to 6/8 19 66 , that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at 4:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE William R. O'Rourke		22b. DATE SIGNED 6/8/66	
22c. PHYSICIAN'S NAME (Type) Dr. William R. O'Rourke		22d. ADDRESS Westminster, Maryland	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/11/1966	23c. NAME OF CEMETERY OR CREMATORY Messiah Lutheran Cemetery	23d. LOCATION (City, town, or county) (State) Carroll Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE C. I. Waltz		25a. REC'D BY REGISTRAR JUN 10 1966	
ADDRESS B ox 241 Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

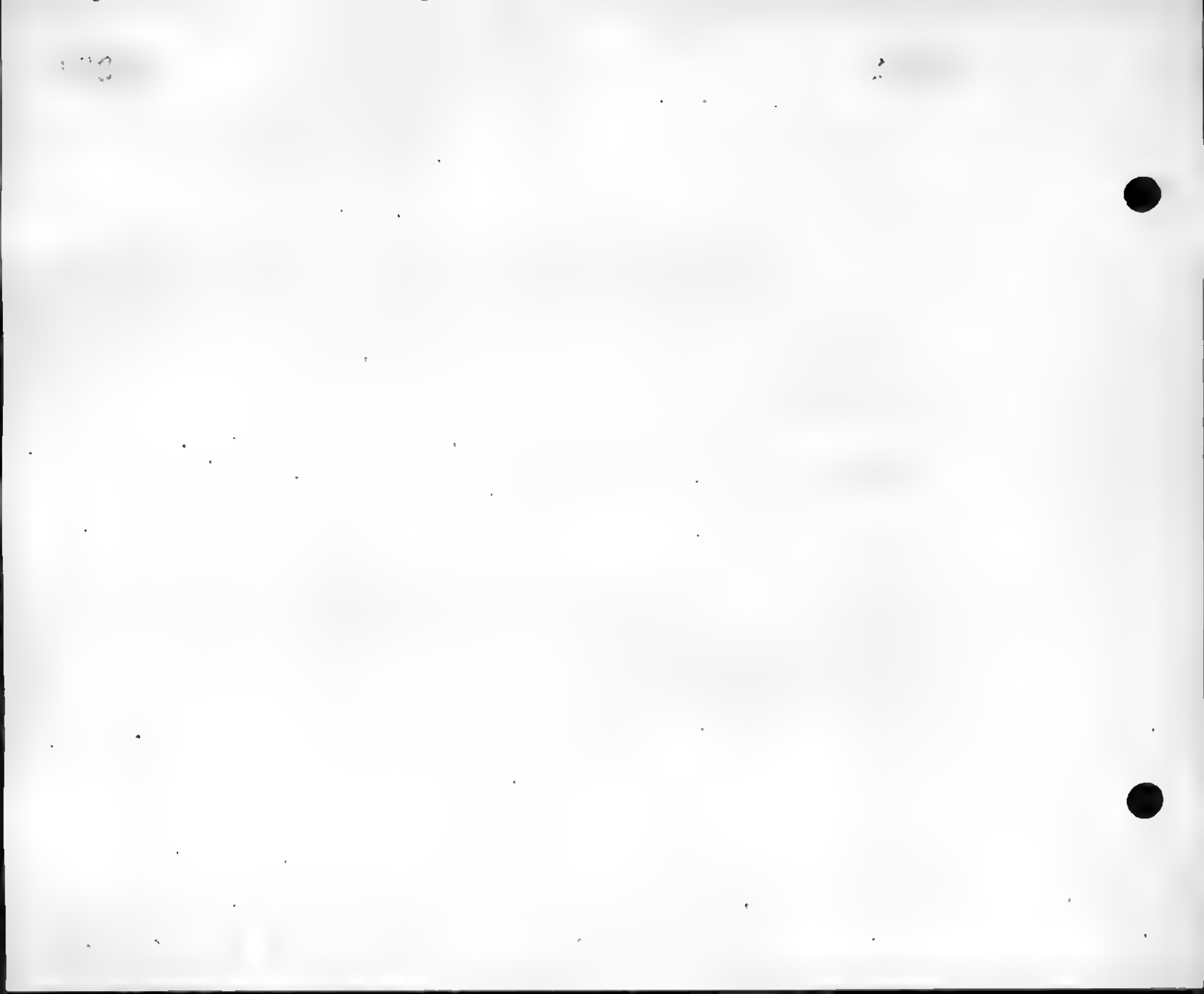


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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08280 <i>Carroll</i> 1. PLACE OF DEATH a. COUNTY <i>Rt. 1, Davis Road, Mt. Olive</i> <i>Woodbine</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i> c. LENGTH OF STAY IN ID <i>06.1</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Rt 1, Davis Road</i>					08269 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i> d. STREET ADDRESS <i>Rt 1, Davis Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <i>Katherine Margaritha Herche</i>			4. DATE OF DEATH Month Day Year <i>June 2 1966</i>		9. AGE (In years last birthday) <i>74</i> yrs. IF UNDER 1 YEAR: Months Days Hours Min. <i>74</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 2, 1892</i>		10. AGE (In years last birthday) <i>74</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Nicholas Schlicker</i>					14. MOTHER'S MAIDEN NAME <i>Christina Schwamm</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>John R. Herche, Rt. 1, Davis Road, Mt. Olive Woodbine, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Cerebral Thrombosis</i> 314 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>ARTERIO SCLEROSIS - GENERALIZED</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>DIABETES MELLITUS, ANGINA PECTORIS 8 YRS. HYPERTENSION</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 YRS</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> , 19, to <i>JUNE 2</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6 2</i> 19 <i>66</i> , and that death occurred at <i>2:4</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>G. Truman Schwab</i>					22b. DATE SIGNED <i>JUN 7 1966</i>			22c. PHYSICIAN'S NAME (Type) <i>G. Truman Schwab</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>June 6, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>		
24. FUNERAL DIRECTOR <i>G. Truman Schwab, 3512 Frederick Ave. Baltimore Maryland 21229</i>					25a. REC'D BY REGISTRAR <i>JUN 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT. **M**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

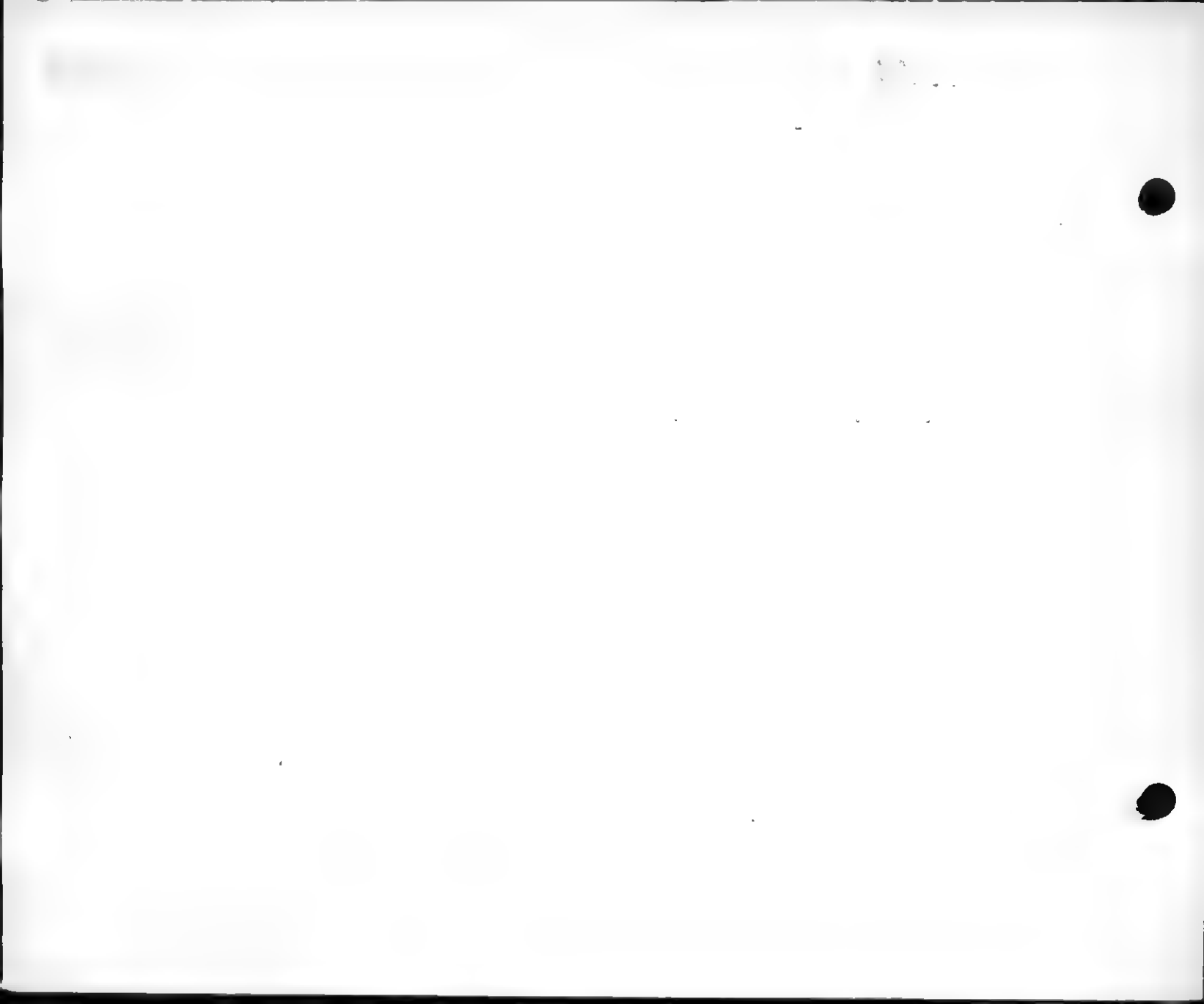
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08281

08270

1 PLACE OF DEATH a. COUNTY CARROLL COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gist c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Longview Farm		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 423 Stratford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MICHAEL Middle CHARLES Last HIPSLEY		4 DATE OF DEATH Month June Day 12 Year 1966	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-14-47
9 AGE (in years last birthday) 19 24x yrs		10 IF UNDER 1 YEAR Months 19 Days 24 Hours 00 Min 00	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Milton A. Hipsley, Sr.		14 MOTHER'S MAIDEN NAME Helene E. Skabisky	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Milton A. Hipsley, Sr.		Address -423 Stratford	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple extremities injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Skydiving - Parachute failed to open. 20c TIME OF INJURY Month Day, Year 5:00 Hour 00 a.m. 6-12 19 66 20d INJURY OCCURRED (a) While at work <input type="checkbox"/> (b) Not While at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Longview Farm 20f (City or town) Gist (County) Carroll, Md. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 22 DATE SIGNED 6-13-66	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6-15-66	23c NAME OF CEMETERY OR CREMATORY Loudon Park	23d LOCATION (City or Town) Balto., Md. (County) (State)
24. FUNERAL DIRECTOR Witzke F.B. - 4101 Edmondson Ave.		25a REC'D BY REGISTRAR JUN 14 1966 DATE 25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

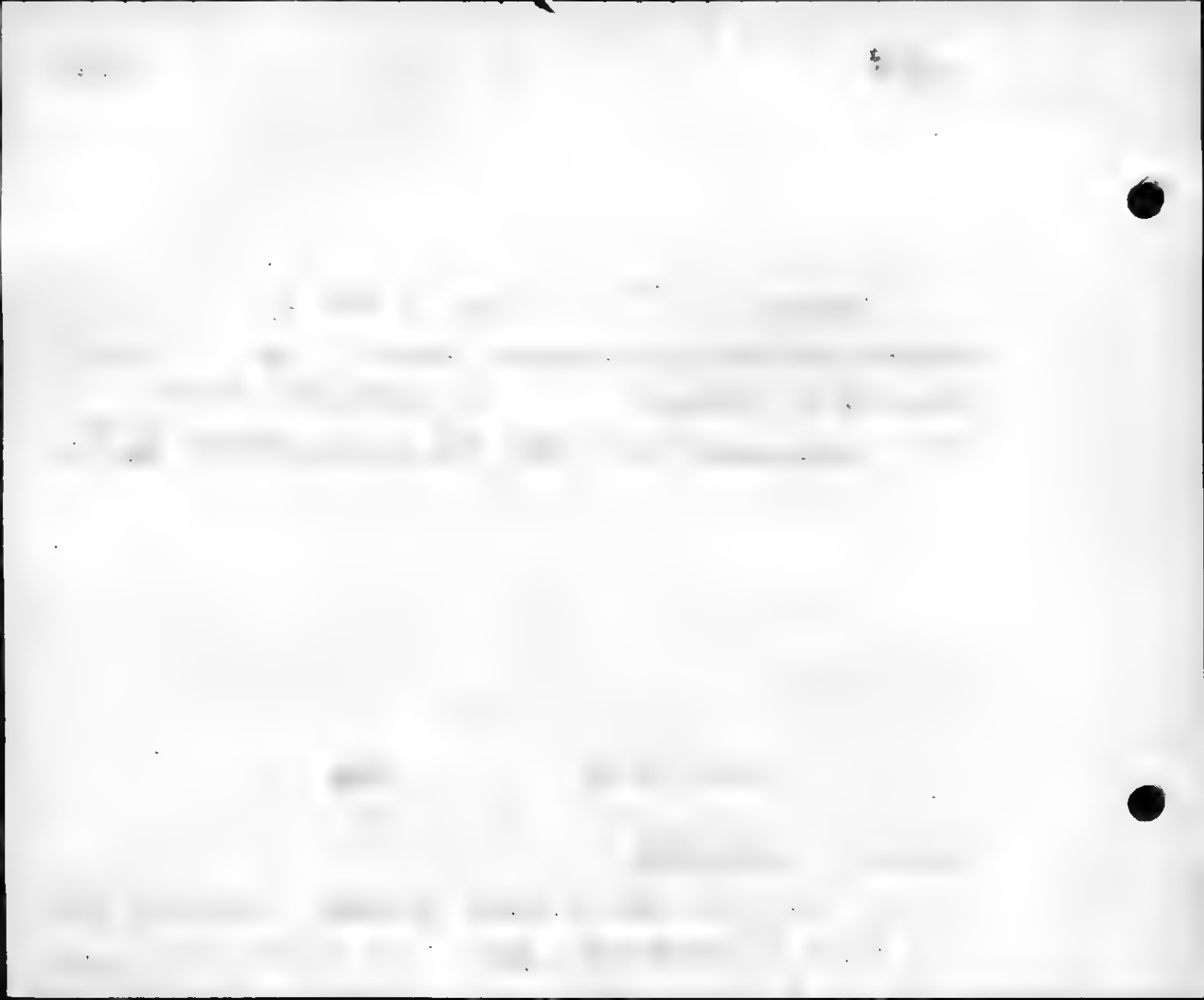
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08282

118271

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>44 RIDGE ROAD</u>				d. STREET ADDRESS <u>44 RIDGE ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN W JANNEY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10, 1894</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEDERAL EMPLOYEE AND SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CEREDO, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM D. JANNEY</u>				14. MOTHER'S MAIDEN NAME <u>M. CLARISSA ROWE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>214-01-6588A</u>		17. INFORMANT <u>MRS JOHN W. JANNEY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> DUE TO (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>1 WEEK</u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>66</u> , to <u>JUNE</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JUNE 13</u> , 19 <u>66</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel I. Welliver</u>				22b. DATE SIGNED <u>6-13-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>				22d. ADDRESS <u>19 RIDGE ROAD WESTMINSTER MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>PIKESVILLE, MD.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08283

CERTIFICATE OF DEATH

08272

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Kent ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN Ib 3 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospital				d. STREET ADDRESS Marling Farms			
3. NAME OF DECEASED (Type or print) GERTRUDE KINDER				4. DATE OF DEATH Month 6 Day 24 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/27/1890	
9. AGE (In years last birthday) 76 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Louis Sigmund			
14. MOTHER'S MAIDEN NAME Lina Machinsky				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 218-18-0948				17. INFORMANT Mr. Ernest Kinder, Chester, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15X Necrotizing vasculitis DUE TO (b) Penicillin allergy DUE TO (c) Penicillin allergy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6/21, 1966 to 6/24, 1966 , that (I) (we) last saw the deceased alive on 6/24, 1966 , and that death occurred at 3:05 M, from causes and on the date stated above.							
22a. SIGNATURE John S. Harshey				22b. DATE SIGNED 6/24/66			
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.				22d. ADDRESS Anchor St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/66		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Upperco Balto. Md.	
24. FUNERAL DIRECTOR Tipton-Eline Fun.Home, Hampstead, Md.				25a. REC'D BY REGISTRAR DATE JUN 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

3 1/2

3 1/2



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

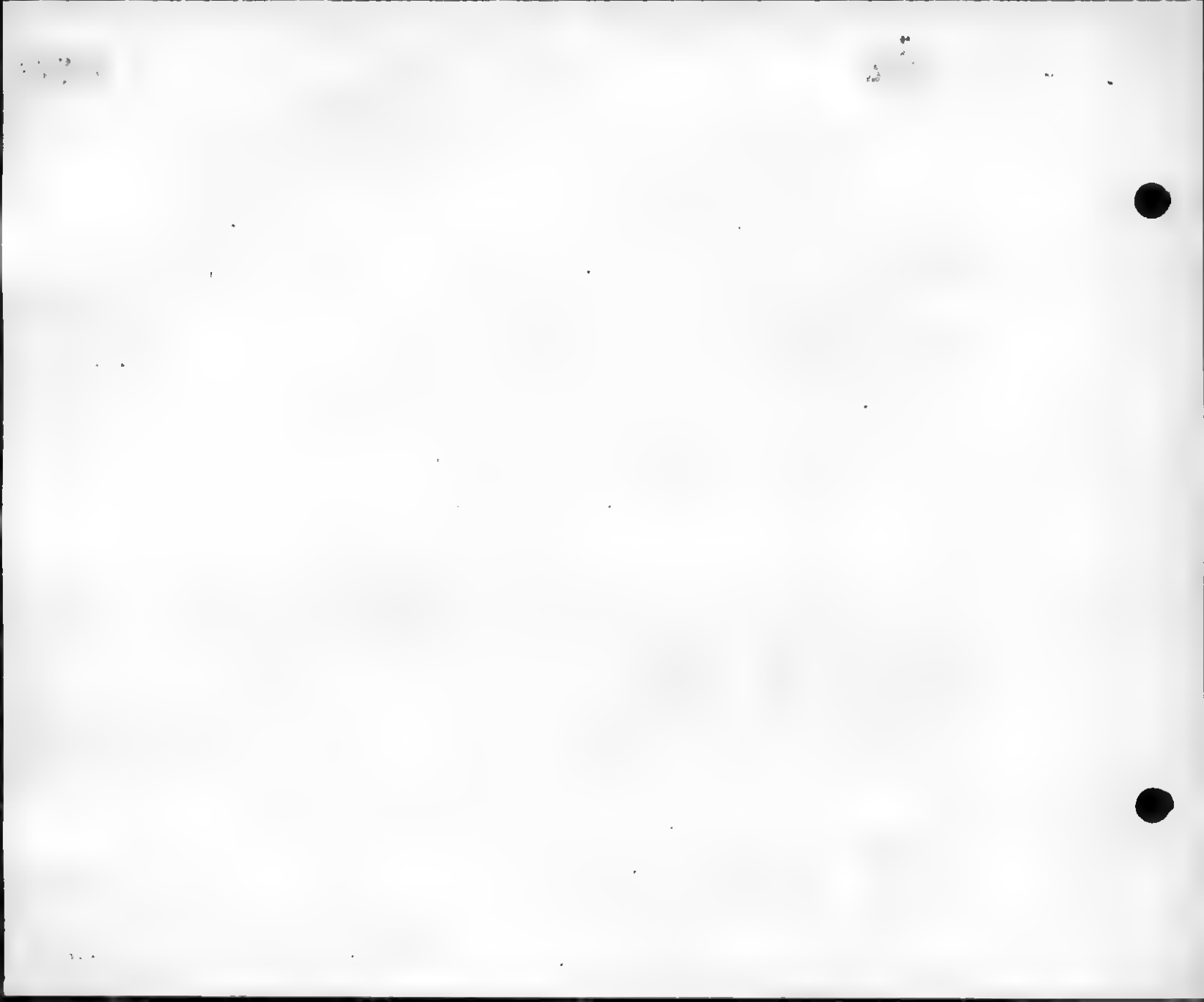
08284

08273

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County Hospital, West		d. STREET ADDRESS 1235 Gladstone Drive	
3. NAME OF DECEASED (Type or print) First PAUL Middle R. Last KING		4. DATE OF DEATH June 13, 1966 19	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1920
9. AGE (In years last birthday) yrs 46		IF UNDER 1 YEAR Months 9 Days 15 Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence King		14. MOTHER'S MAIDEN NAME Ruth Trott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.	
17. INFORMANT Nancy H. King - wife - same item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1201 OU E TO (c) 1201			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/13, 1966 , to 6/13, 1966 , that (I) (we) last saw the deceased alive on 6/13, 1966 , and that death occurred at 6:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE John S. Harshey M.D.		22b. DATE SIGNED 6/13/66	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Archer St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25. REC'D. BY REGISTRAR 1331 Rockville, Rockville, Md.	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08285

08274

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>1 Hour</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u> d. STREET ADDRESS <u>Rural - New Windsor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Philip Koller</u>				4. DATE OF DEATH Month Day Year <u>6 5 1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/5/66</u>		9. AGE (In years last birthday) yrs. <u>1</u> <u>17</u>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Philip L. Koller</u>						14. MOTHER'S MAIDEN NAME <u>Emma Pittenger</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Emma Koller</u> Address <u>Rt. 2 Sykesville, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diaphragmatic Hernia</u> <u>5604</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>BIRTH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-5</u> , 19 <u>66</u> , to <u>6-5</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>6-5</u> , 19 <u>66</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Karl M. Green</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>KARL M. Green MD</u>						22d. ADDRESS <u>181 Fairfield Ave, Westminster</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Freedom Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Carroll Co., Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>						ADDRESS <u>Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Manchester c. LENGTH OF STAY IN MD 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Westminster Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Manchester d. STREET ADDRESS Westminster Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle LEROY Last LEESE, Jr.		4. DATE OF DEATH Month 6 Day 9 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1937
9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Laundry & Cleaners--Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul L. Leese, Sr.		14. MOTHER'S MAIDEN NAME Hilda Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-34-0073	
17. INFORMANT Mrs. Fay Leese		Address Manchester, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Base of Skull DUE TO Fracture of both humeri (b) Fracture of R. humerus (c) Fracture of R. humerus & Ulna Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Motor Vehicle Accident		INTERVAL BETWEEN ONSET AND DEATH 30 mins	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) motorcycle - head on collision with car	
20c. TIME OF INJURY Month, Day, Year 7 Hour a.m. 6-9 p.m. 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Manchester Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Maurice C. Portier EXAMINER'S NAME (Type) active		22. DATE SIGNED 6-9-66 HAMPSTEAD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/12/66	
23c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery		23d. LOCATION (City, town or county) (State) Manchester Md.	
24. FUNERAL DIRECTOR Tipton-Eline		25a. REC'D BY REGISTRAR JUN 14 1966	
ADDRESS Hampstead, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

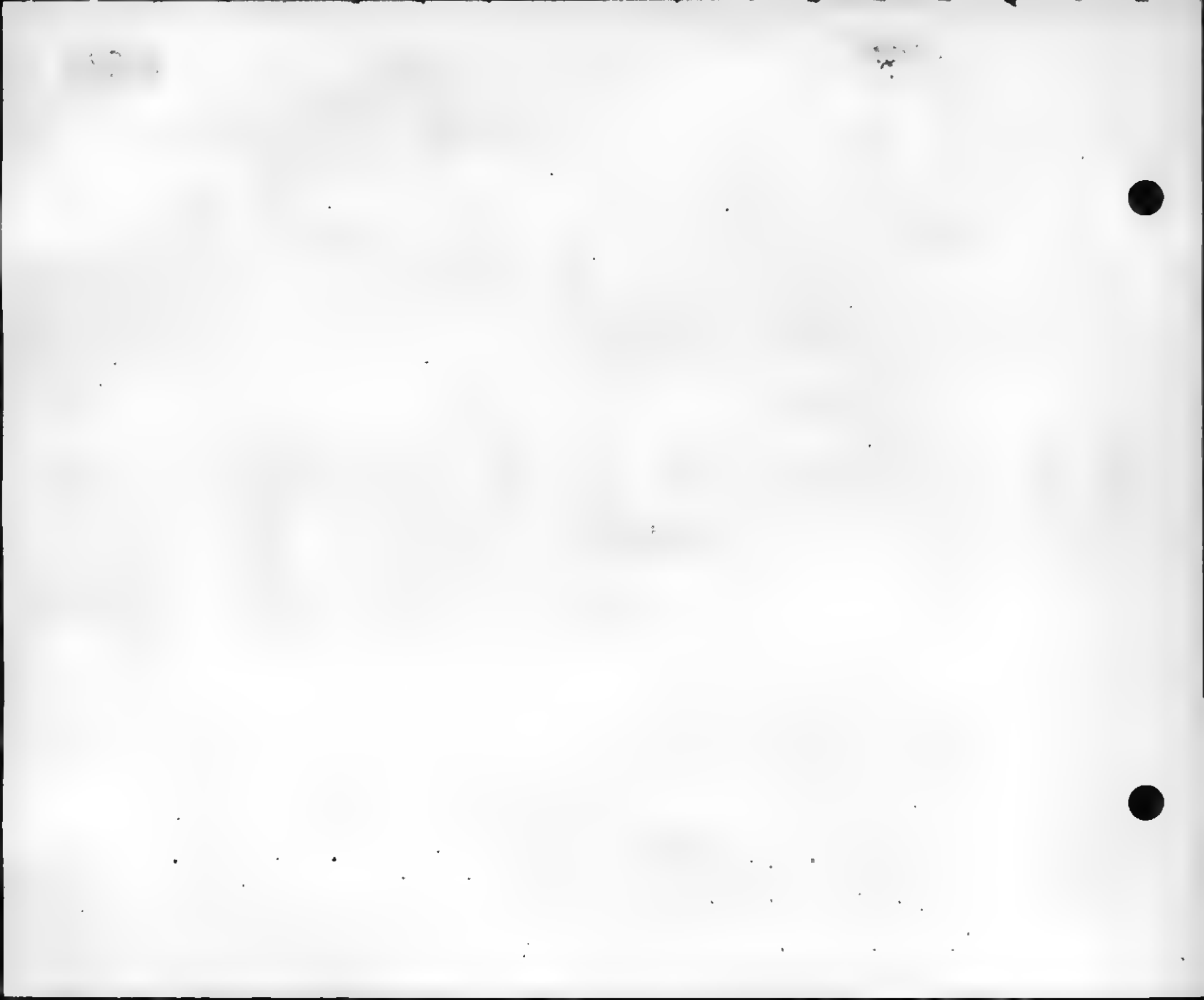
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08287

08276

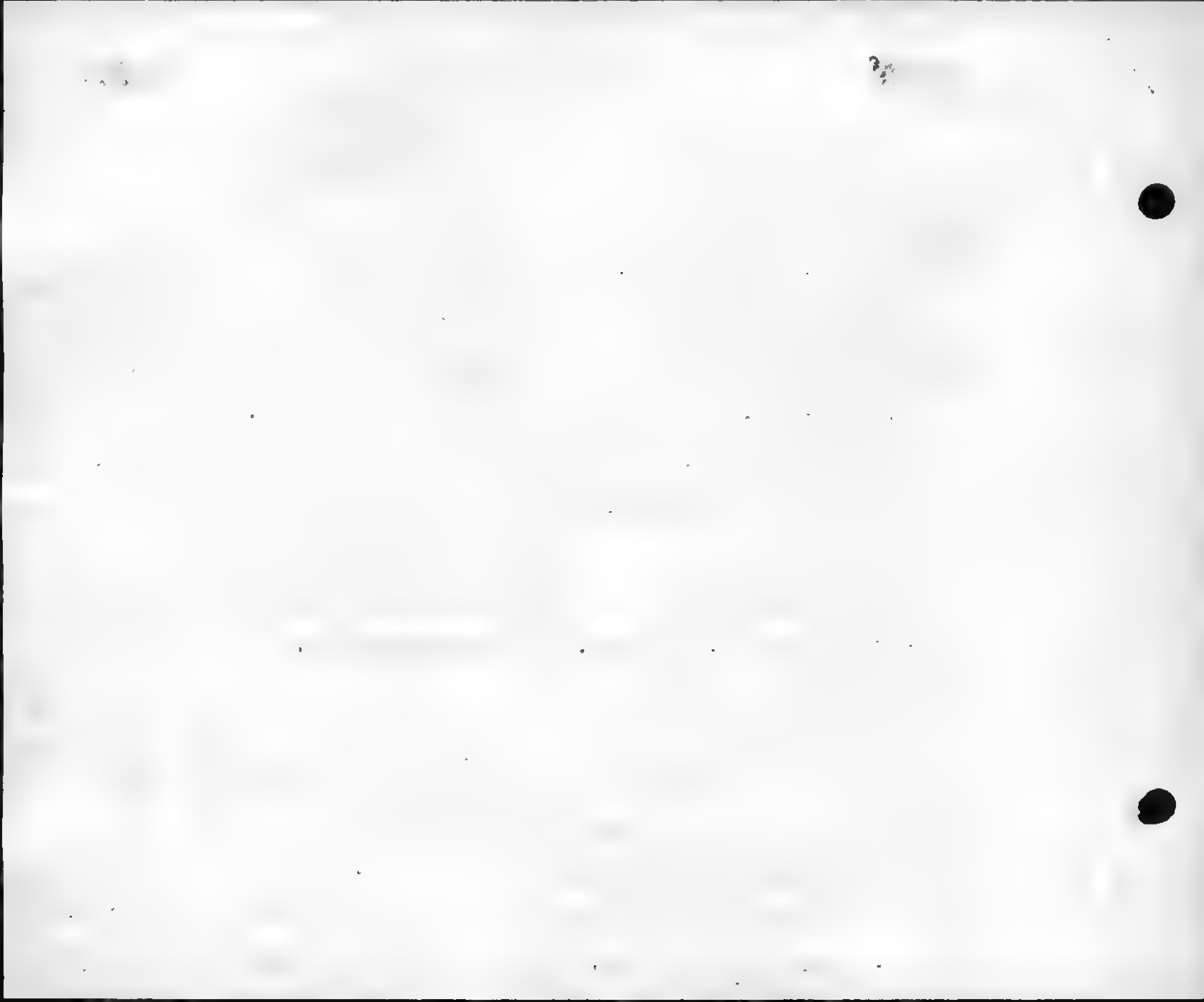
1. PLACE OF DEATH a. COUNTY CARROLL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7 months 22 days			
c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS No fixed Address			
3. NAME OF DECEASED (Type or print) John N M N Lennan				4. DATE OF DEATH Month June Day 4 Year 1966			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1905	
9. AGE (in years last birthday) 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) orderly		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (County & State, or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? UK				13. FATHER'S NAME William Lennan			
14. MOTHER'S MAIDEN NAME Not known				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Ca DUE TO (b) Ascites DUE TO (c) Ascites CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH One mo. weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 10-13 , 19 65 , to 6-4 , 19 66 , that (I) (we) last saw the deceased alive on 6-4 19 66 , and that death occurred at 7 A. M. from the causes and on the date stated above.			
22a. SIGNATURE R. G. Lajonchere MD				22b. DATE SIGNED 6-4-66			
22c. PHYSICIAN'S NAME (Type) R. Lajonchere				22d. ADDRESS Springf. state Hosp.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-11-66			
23c. NAME OF CEMETERY OR CREMATORY New Cathedral				23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Arthur H. Haight				25a. REC'D BY REGISTRAR Charles Judge			
25b. REGISTRAR'S SIGNATURE Charles Judge				DATE JUN 13 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
08288						CERTIFICATE OF DEATH						08277	
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN lb 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 20852							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS 6716 Tildenwood Lane						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adelbert Frank ORMSBY						4. DATE OF DEATH Month June Day 25 Year 1966							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 7-15-87		9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months 11 Days 10		IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - retired				10b. KIND OF BUSINESS OR INDUSTRY ??		11. BIRTHPLACE (County & State, or foreign country) Wisconsin				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Ormsby - dec.						14. MOTHER'S MAIDEN NAME Jennie Misick - dec.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Reserves-2 yrs.				16. SOCIAL SECURITY NO. 360-10-9337		17. INFORMANT Address Springfield State Hosp., Sykesville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 521x Pulmonary abscess IMMEDIATE CAUSE (a) Pulmonary abscess DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 												INTERVAL BETWEEN ONSET AND DEATH weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease. Old subdural hematoma.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 6-2-66 , 19 66 , to 6-25-66 , 19 66 , that (I) (we) last saw the deceased alive on 6-25-66 , 19 66 , and that death occurred at 7 P.M. from causes and on the date stated above.													
22a. SIGNATURE Naci N. Buyukinisal, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-25-66					
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukinisal, MD.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 28, 1966		23c. NAME OF CEMETERY OR CREMATORY Parklawn				23d. LOCATION (City or Town) (County) (State) Rockville Maryland					
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE JUN 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08289 CERTIFICATE OF DEATH 08278

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead - Route 2</u>	
c. LENGTH OF STAY IN 15 <u>1 yr.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long View Nursing Home, Inc.</u>		b. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Elizabeth Patterson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-19-1869</u>	
9. AGE (In years last birthday) <u>96 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll - Manchester, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Virgie Baublitz</u>		Address <u>Hampstead, Md. Route 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>4221</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 15</u> , 19 <u>66</u> , to <u>June 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 5</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush</u>		22b. DATE SIGNED <u>6/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>Hampstead, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Beckleyville</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton-Eline</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1966</u>	
ADDRESS <u>Hampstead, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

28 P3-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08290

08279

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 4yrs. 11mo. 27da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2702 Goodwood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First MARIE Middle (NMN) Last RAMMES		4. DATE OF DEATH Month JUNE Day 27 Year 19 66		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-29-04		9. AGE (in years last birthday) 61 yrs. IF UNDER 1 YEAR: Months 6 Days 1 Hours 1 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Department Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gernhardt				14. MOTHER'S MAIDEN NAME Rose				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-14-7007				17. INFORMANT Records Address Sykesville Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Imitation and dehydration DUE TO Pre-senile brain disease (b) Fecal impaction. Multiple decubitus. DUE TO Chronic brain syndrome associated with presenile brain disease with psychotic reaction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with presenile brain disease with psychotic reaction.														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 12				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 6-30- 19 61 to 6-27- 19 66 that (I) (we) last saw the deceased alive on 6-27- 19 66 , and that death occurred at 12:10 A.M. from the causes and on the date stated above.																					
22a. SIGNATURE Ernest Beiser, M.D.										22b. DATE SIGNED June 27, 1966											
22c. PHYSICIAN'S NAME (Type) Ernest Beiser, M.D.										22d. ADDRESS Springfield State Hospital Sykesville, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-30-66		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery				23d. LOCATION (City, town or county) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home Inc.										25a. REC'D BY REGISTRAR Charles Judge DATE JUN 30 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08291

08280

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Mount Airy</u>	
c. LENGTH OF STAY IN 1b <u>11 years</u>		d. STREET ADDRESS <u>Md. Route 144</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Md. Route 144</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Albert Randle</u>		4. DATE OF DEATH Month Day Year <u>June 11 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1890</u>
9. AGE (In years last birthday) <u>76</u> ym.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motor Express</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Randle</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-9342</u>	
17. INFORMANT <u>Mrs. Charles A. Randle, Mt. Airy, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4501</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 1963</u> to <u>June 1966</u> , that (I) (we) last saw the deceased alive on <u>June 4 1966</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Culwell</u>		22b. DATE SIGNED <u>June 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		22d. ADDRESS <u>Mount Airy, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-14-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.D. Sautz, Box 241, Sykesville, Md</u>		25a. REC'D BY REGISTRAR <u>JUN 14 1966</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

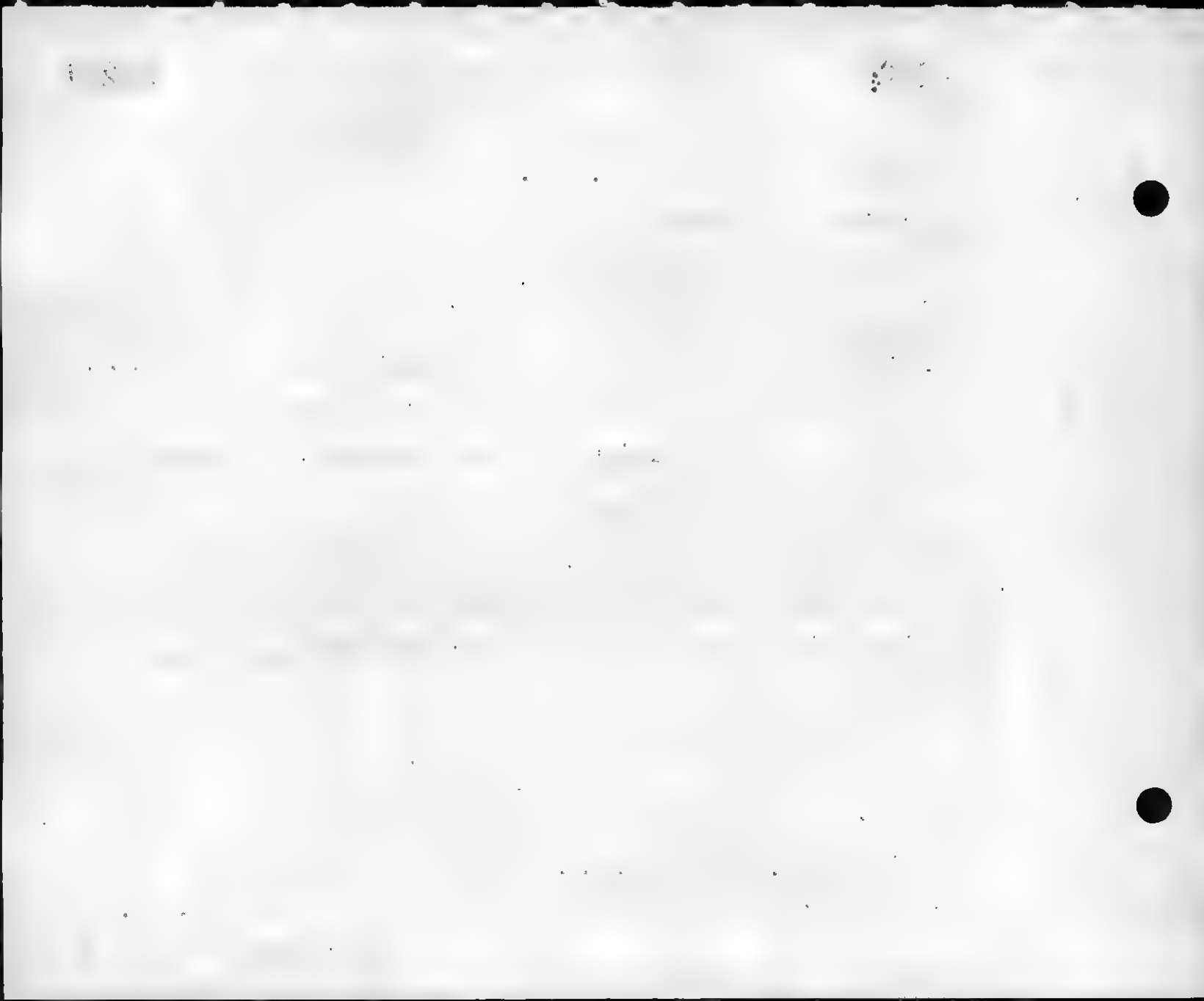
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08281

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia	
c. LENGTH OF STAY IN 1b 1mo. 1 dy.		d. STREET ADDRESS Unk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			
3. NAME OF DECEASED (Type or print) DOROTHY MAY RANDOLPH		4. DATE OF DEATH June 17 1966	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-29
9. AGE (In years last birthday) 37 yrs.		10. FINDER 1 YEAR Months Days Hours Min.	11. FINDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Howard Duvall	
14. MOTHER'S MAIDEN NAME Edith Taylor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-26-0498		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, Chronic Undifferentiated type			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Maurice C. Porterfield		22. DATE SIGNED 6-17-66	
EXAMINER'S NAME (Type) Maurice D. Porterfield, M.D.		23. ADDRESS HAMPSTEAD, CARROLL	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6/22/66	23c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery	23d. LOCATION (City, town or county) (State) Clarksburg, Md.
24. FUNERAL DIRECTOR George R. Snowden		25a. REC'D BY REGISTRAR JUN 23 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

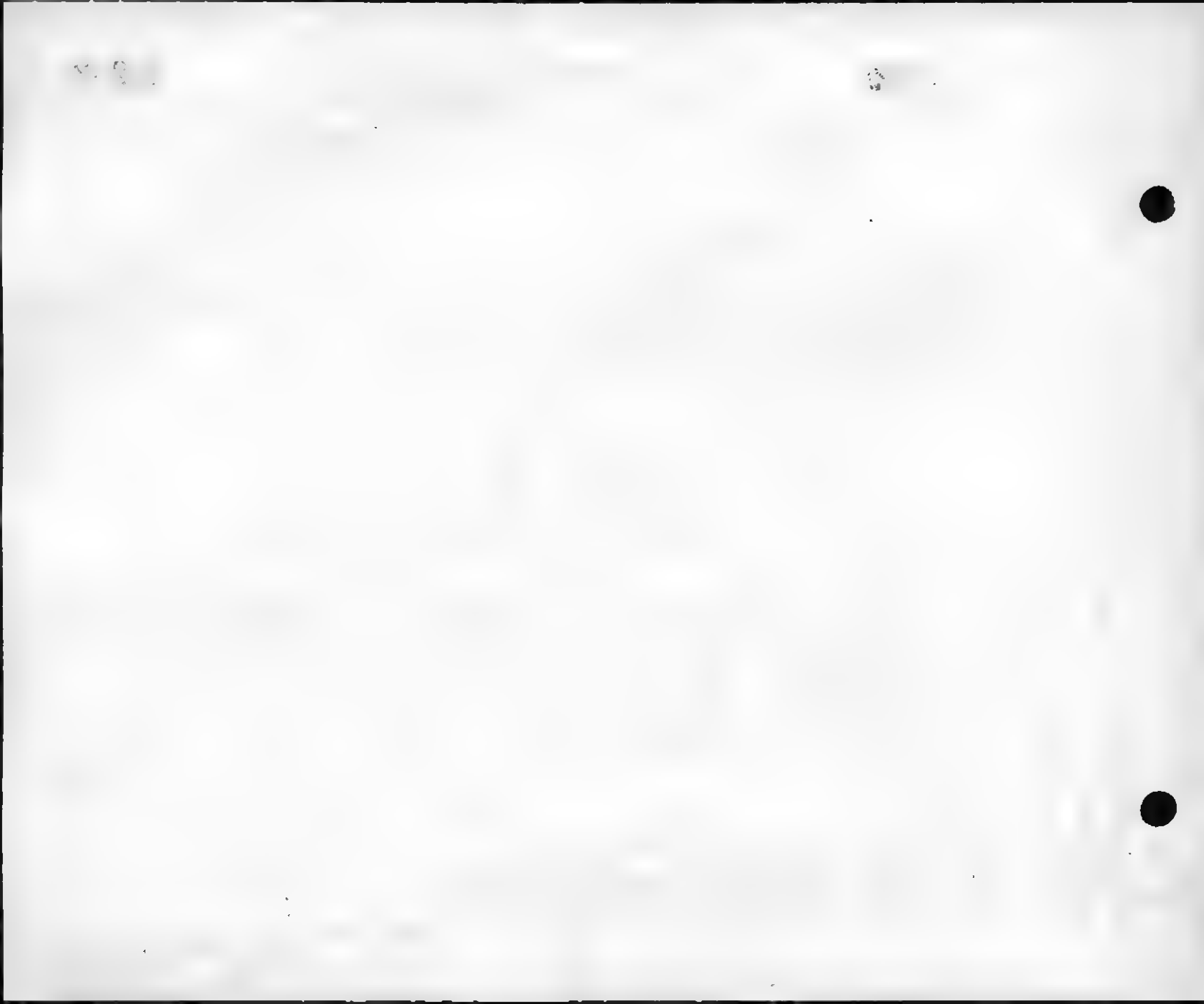
08293

08282

1 PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY City Jo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 3904 Southern Ave.	
3 NAME OF DECEASED (Type or print) First John Middle None Last Ray		4. DATE OF DEATH Month June Day 18 Year 1966	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-95
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Russia Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuanian	
13. FATHER'S NAME Anton		14. MOTHER'S MAIDEN NAME ? Unknown.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-54-7420	
17. INFORMANT Hospital records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CVA - Hemorrhage. DUE TO (b) Arterio-sclerotic cardiovascular disease DUE TO (c) generalized arterio-sclerosis.			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with brain trauma, years prior without qualifying phrase			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-16-1958 , to 6-18-1966 , that (I) (we) last saw the deceased alive on 6-18-1966 , and that death occurred at 6 A.M. from causes and on the date stated above.			
22a. SIGNATURE Suha Ozgun.		22b. DATE SIGNED 6-18-66	
22c. PHYSICIAN'S NAME (Type) SUHA OZGUN		22d. ADDRESS Springfield State Hosp. Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6-25-66	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) BALTO. Md.
24. FUNERAL DIRECTOR Harry W. Knight		25a. REC'D BY REGISTRAR Sykesville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 27 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

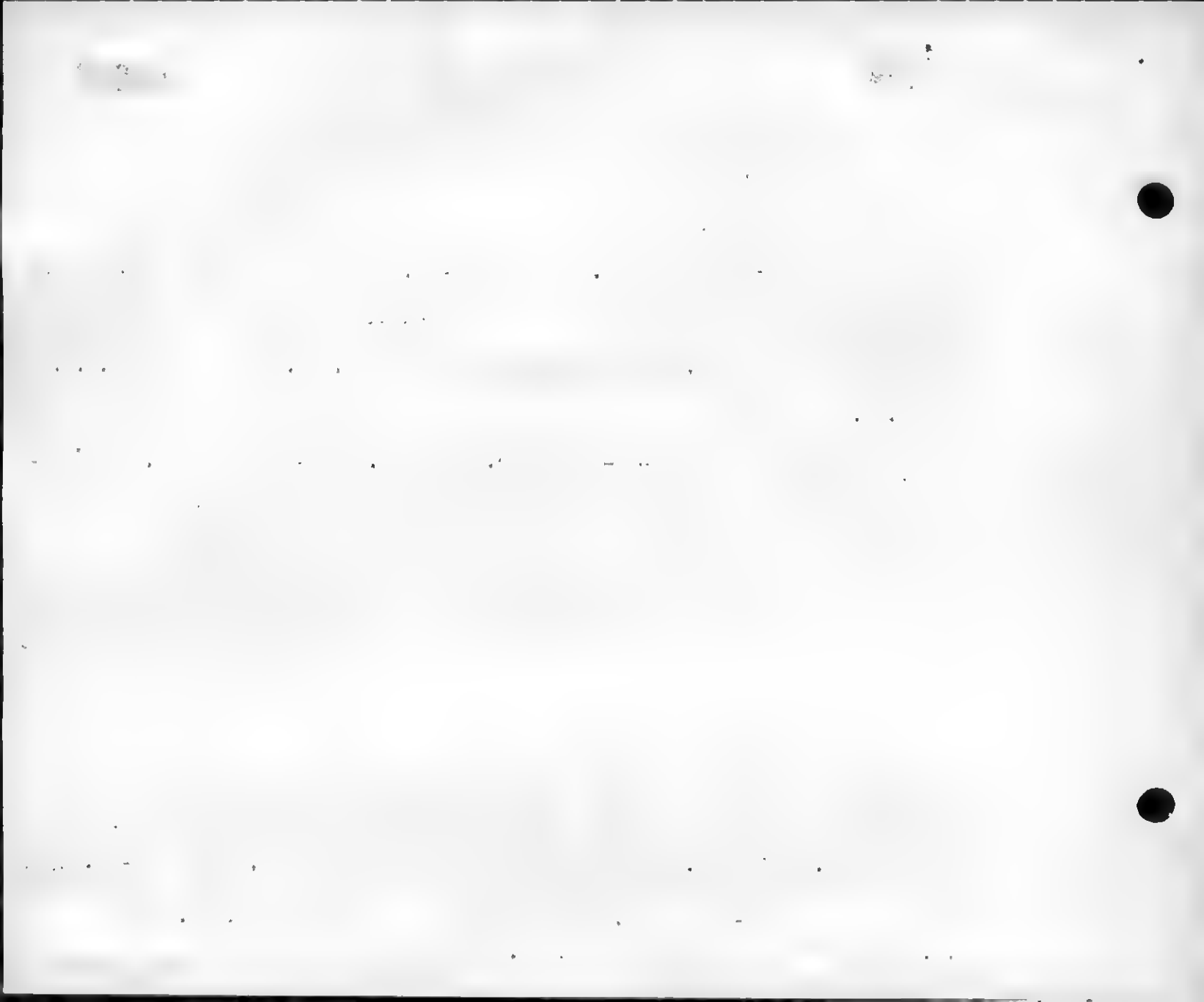
08294

08283

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll County Hospital		e. STREET ADDRESS Dulaney Avenue	
3 NAME OF DECEASED (Type or print) First Paul Middle W. Last Rice-Sr.		4 DATE OF DEATH Month June Day 1- Year 19 66	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11-1911
9 AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months 5 Days 4 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY R. Road Brakeman	
11 BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. C. Rice- living		14. MOTHER'S MAIDEN NAME Ada Rebecca Ausherman- deceased	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or Unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-2222	
17. INFORMANT Mrs. Myrtle E. Rice- Dulaney Ave. Frederick-		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) Sudden Death		INTERVAL BETWEEN ONSET AND DEATH 5 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 , 19 62 , to 1966 that (I) (we) last saw the deceased alive on 5/31 19 66 , and that death occurred at 3:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Richard C Reynolds, M.D.		22b. DATE SIGNED June 2-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave.-Frederick-Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 4-1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR Edwood J. Whitmore	
25b. REGISTRAR'S SIGNATURE Frederick, Md. 21701		25c. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



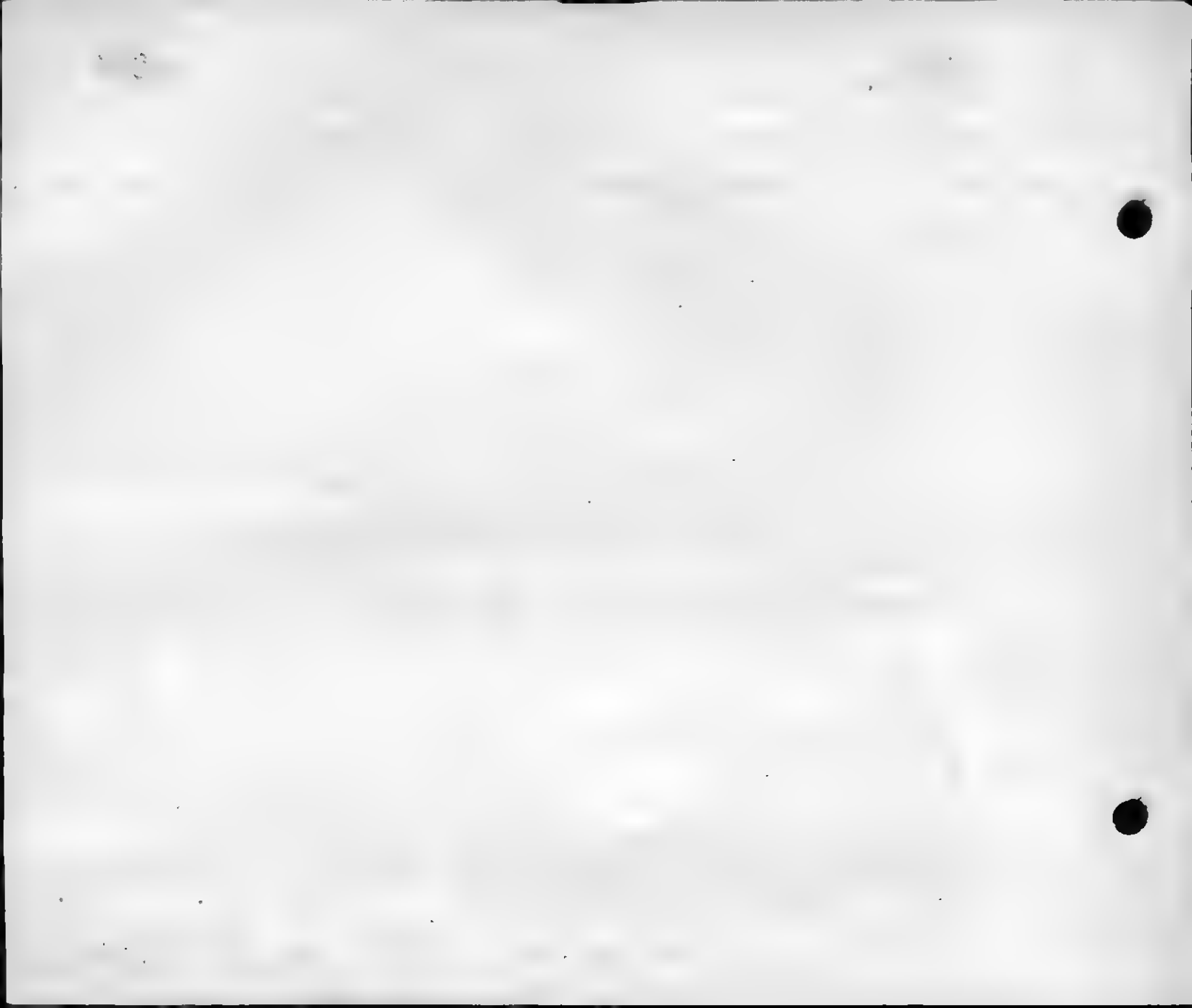
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08295		Item 13 Film 3378 7/1/66 mh		08284	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Houchesville Rd</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - HAMPSTEAD</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Lorraine</u> Last <u>Richards</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1966</u>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1897</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nora Virginia Brunnel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-36-8781</u>		17. INFORMANT <u>Frank A Richards Hampstead Md</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) <u>Chronic Myocarditis</u> <u>Hypertensive Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (i) (this hospital) attended the deceased from <u>9/19/1965</u> to <u>June 23, 1966</u> ; that (I) (we) last saw the deceased alive on <u>June 10, 1966</u> , and that death occurred at <u>4:15</u> A.M. from the causes and on the date stated above					
22a. SIGNATURE <u>Joseph E. Bush</u>		22b. DATE SIGNED <u>June 23 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>	
22d. ADDRESS <u>Hampstead Maryland</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>		22f. REGISTRAR'S SIGNATURE <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>	
23d. LOCATION (City, town or county) <u>Carroll Co.</u>		23e. (State) <u>Md.</u>		23f. REC'D BY REGISTRAR <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline</u>		24a. ADDRESS <u>Hampstead, Md.</u>		24b. DATE <u>JUN 28 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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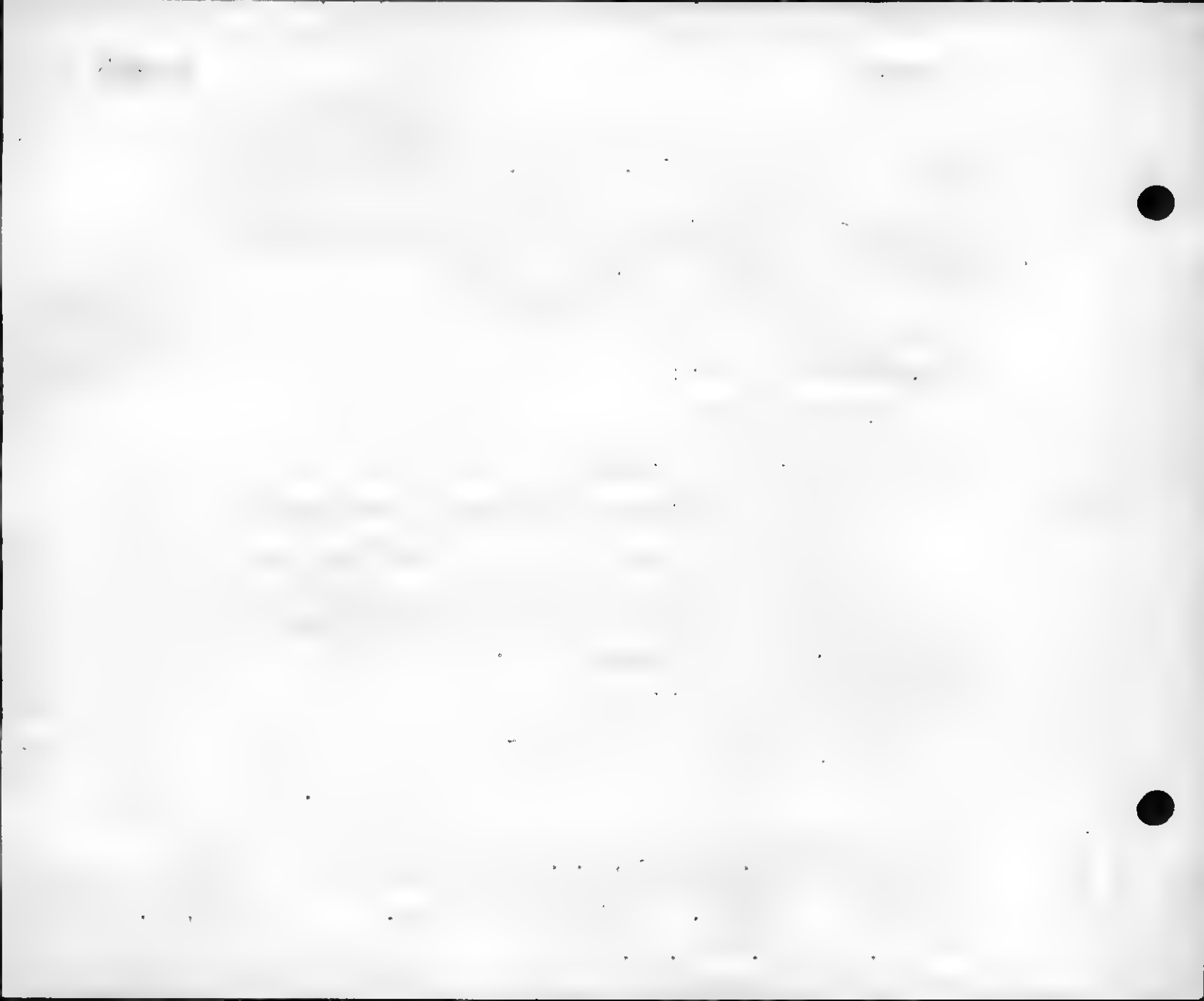
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08296

08285

1 PLACE OF DEATH a. COUNTY Carroll Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 15 0yr. 0mo. 6d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 21214 d. STREET ADDRESS 5318 Grindon Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Laurence (NMN) Richmond First Middle Last 4 DATE OF DEATH 6 9 19 66 Month Day Year		5 SEX male 6 COLOR OR RACE white 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7-22-95 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Holland Richmond 14. MOTHER'S MAIDEN NAME Nancy Wright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, Navy 19-18-1919 16. SOCIAL SECURITY NO. 216-07-8941 17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure due to renal insufficiency DUE TO (b) Arteriosclerotic cardiovascular disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arterio-sclerosis, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --:-- 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from 6-3 , 1966, to 6-9 , 1966, that (X) (we) last saw the deceased alive on 6-9 , 1966, and that death occurred at 10:50 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Heinz H. Klaatsch M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D. 22d. ADDRESS Springfield State Hospital		22b. DATE SIGNED 6-10-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 6/13/66. 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 ADDRESS 25a. REC'D BY REGISTRAR JUN 14 1966 DATE 25b. REGISTRAR'S SIGNATURE J. Charles	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08297

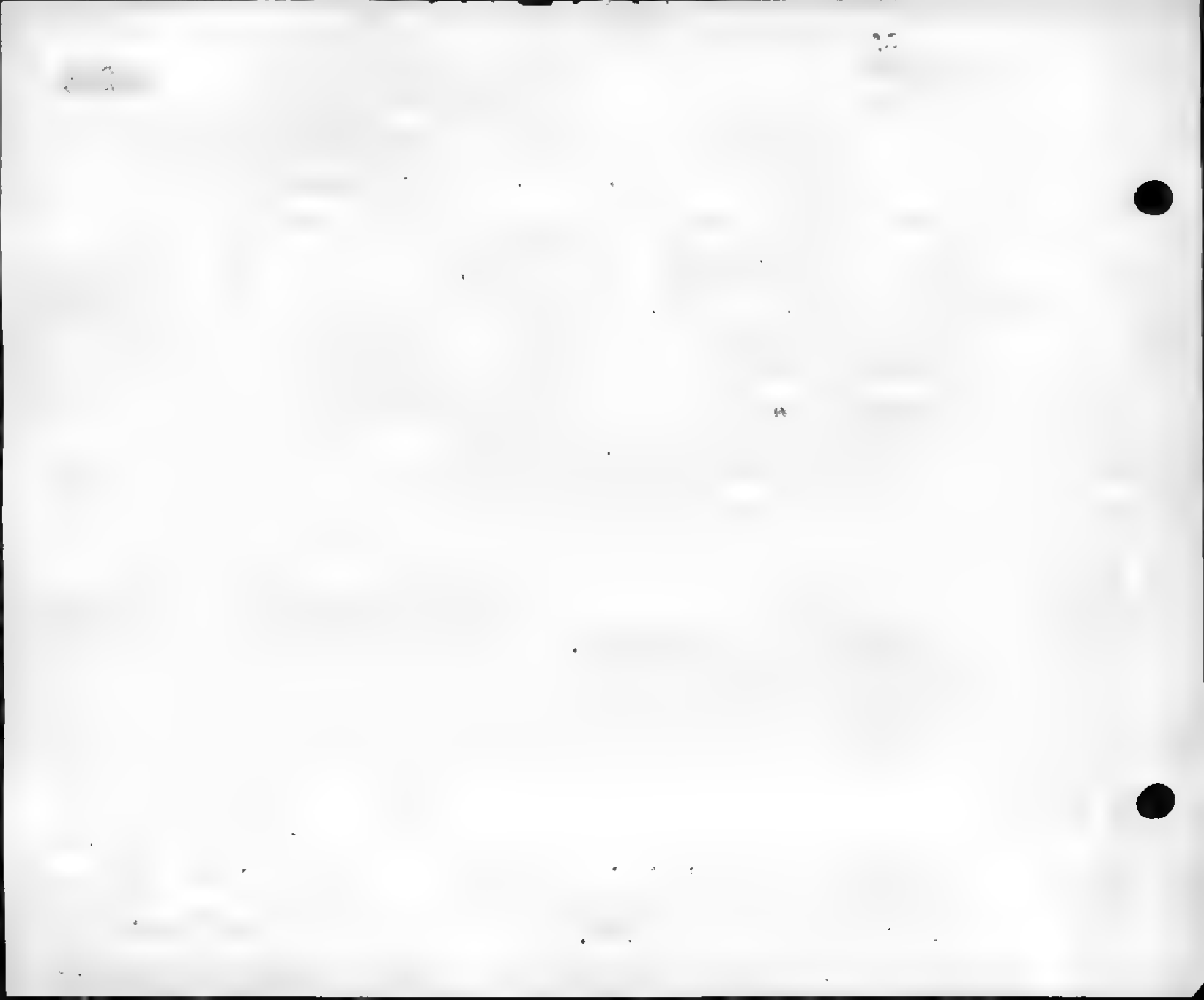
CERTIFICATE OF DEATH

08286

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville			c. LENGTH OF STAY IN 1b 4mo. 13days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 76 Church Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Hunt Last Rogers				4. DATE OF DEATH Month 6 Day 8 Year 1966			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/92		9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Brattan				14. MOTHER'S MAIDEN NAME Elizabeth Hunt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Springfield Hospital records, Sykesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Branchopneumonia DUE TO (b) Arterio-sclerotic cardiovascular disease DUE TO (c) years.							INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with alcohol intoxication without qualifying phrase.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 1-25- , 19 66 , to 6-8 , 19 66 , that (we) last saw the deceased alive on 6-8 , 19 66 , and that death occurred at 1 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Suha Ozgun				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6/8/66	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6/10/66		23c. NAME OF CEMETERY OR CREMATORY St Johns		23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.	
24. PLACE OF BIRTH Ellicott City, Md.				25a. REC'D BY REGISTRAR J.C. Higginbotham, Ellicott City, Md.		25b. REGISTRAR'S SIGNATURE J.C. Higginbotham	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

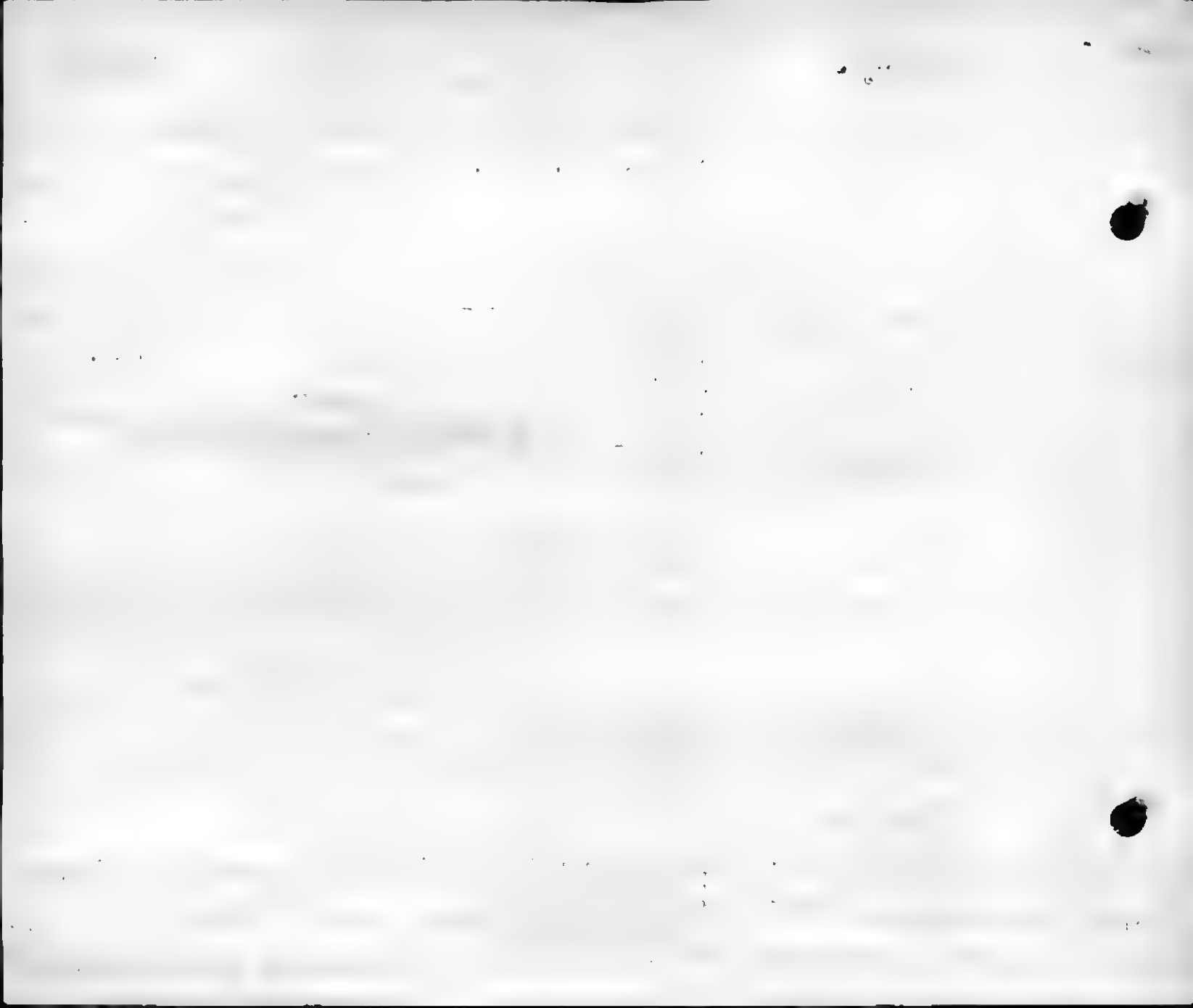
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SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08298

08287

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN b 1 yr. 1 mo. 7 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2665 Oswego Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RONALD MYRON ROSEN				4. DATE Month Day Year June 7 19 66 DEATH			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mitchell Rosen				14. MOTHER'S MAIDEN NAME Barbara Bauer Bauer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-5588		17. INFORMANT MITCHELL ROSEN 3624 FORDS LANE #15			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (b) Drug Addictions (Overdose) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Baltimore	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Maurice C. Porterfield EXAMINER'S NAME (Type) Maurice C. Porterfield, M.D. Hampstead, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-7-66			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 10, 1966		22c. NAME OF CEMETERY OR CREMATORY OHEL YAKOV CONG		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR Edwinson & Sons ADDRESS 6010 REGISTER TOWN ROAD				24a. REC'D BY REGISTRAR JUN 14 1966 24b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

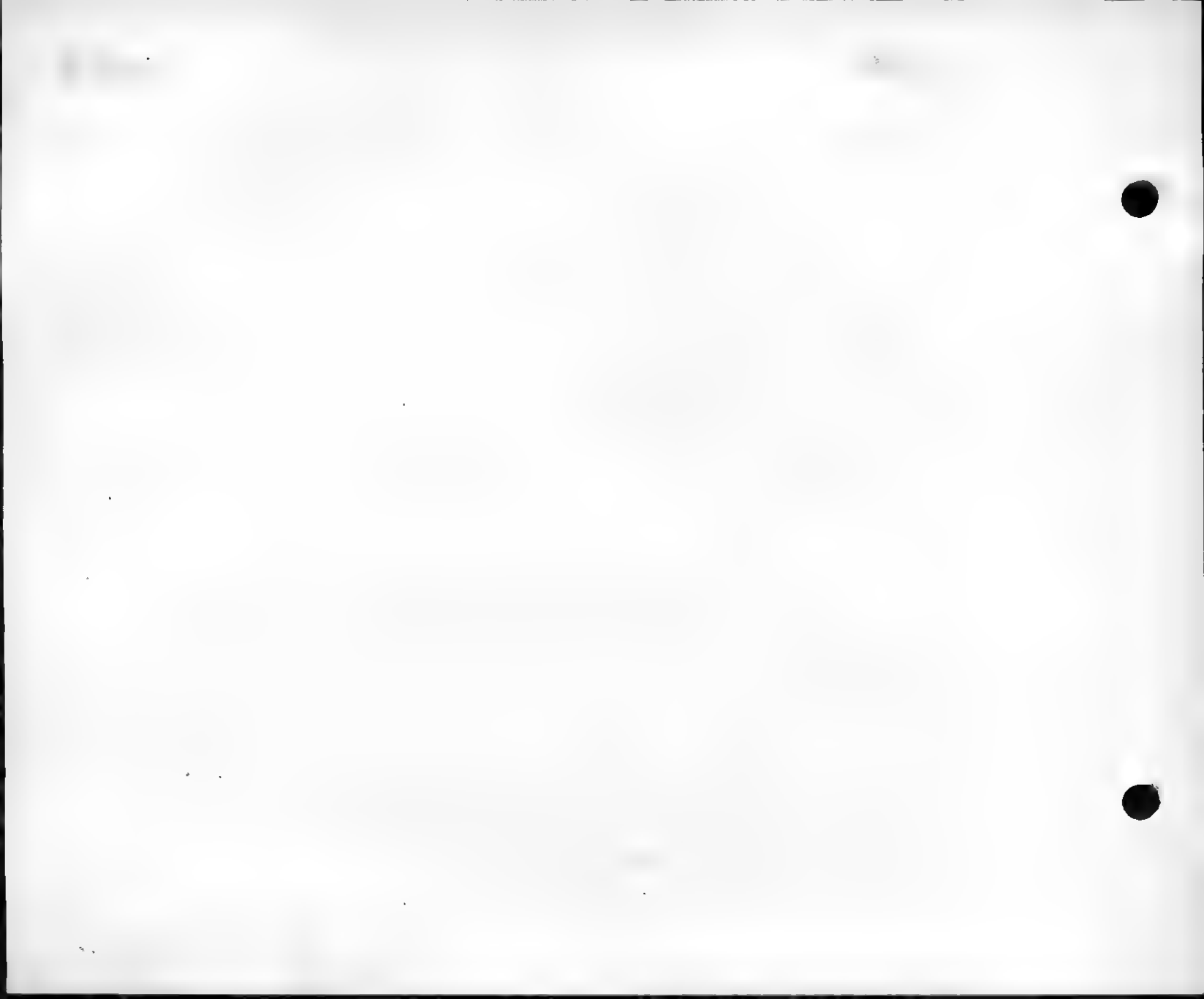
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08299

08288

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN ID <u>acute care</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 East George St.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>25 East George St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA MARIE ROTHENBERGER</u>				4. DATE OF DEATH <u>JUNE 16 1966</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1913</u>	
9. AGE (In years last birthday) <u>52 yrs.</u>		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Westminster, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>operator in clothing factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>clothing factory</u>			
13. FATHER'S NAME <u>David William Rothenberger</u>				14. MOTHER'S MAIDEN NAME <u>Martha Helena Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-14-6422</u>		17. INFORMANT <u>Charles W. Rothenberger</u> Address <u>same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>170X</u> DUE TO (b) <u>metastatic carcinoma of breast</u> DUE TO (c) <u>1 year</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1, 1945</u> , to <u>June 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 16, 1966</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>C. L. Billingslea</u> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>	
22d. ADDRESS <u>Westminster, Md.</u>				22e. REC'D BY REGISTRAR <u>JUN 20 1966</u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				22g. NAME OF CEMETERY OR CREMATORY <u>St. John's Catholic Cemetery, Westminster, Md.</u>			
22h. LOCATION (city, town or county) (State)				22i. DATE THEREOF <u>6/20/66</u>			
22j. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22k. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

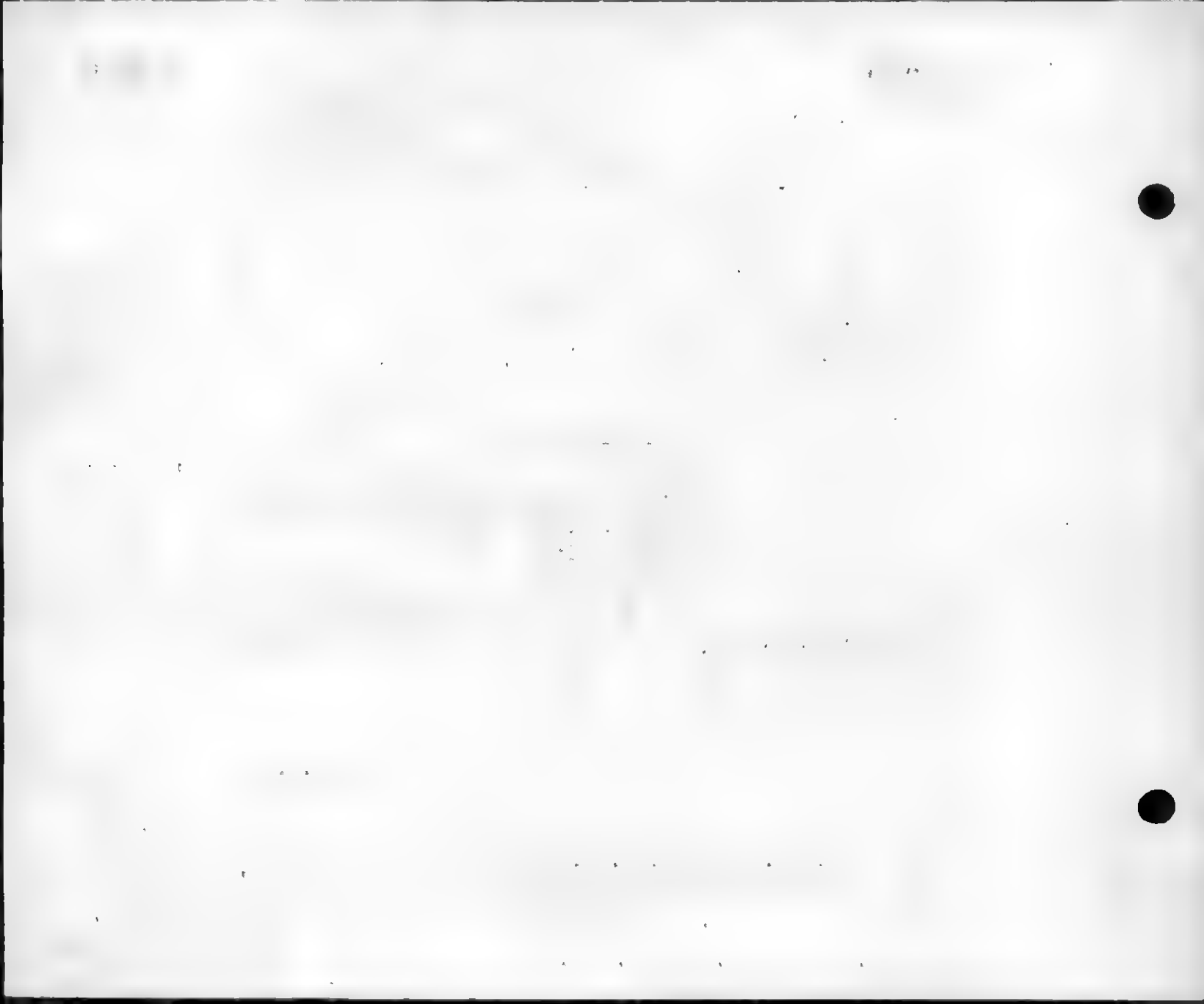
08300

08289

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville c. LENGTH OF STAY IN lb 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30-1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3102 Rueckert Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Regina Russell			4. DATE OF DEATH Month Day Year 6 7 1966				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/26/20	9. AGE (In years last birthday) yrs. 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk		10b. KIND OF BUSINESS OR INDUSTRY Credit Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Sinclair			14. MOTHER'S MAIDEN NAME Mary Sturgeon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-03-5726		17. INFORMANT Address Springfield Hospital records, Sykesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septic infarction of the right hemisphere of the brain, organism unknown DUE TO (b) Acute meningitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH Days or weeks Days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome with circulatory disorder (CVA) with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from 5/23/1966 to 6/7/1966 , that (we) last saw the deceased alive on 6/7/1966 , and that death occurred at 8:25 P.M. from causes on and on the date stated above.							
22a. SIGNATURE Luis J. Arribas, M.D. M.D.			22b. DATE SIGNED 6/8/66		22c. PHYSICIAN'S NAME (Type) Luis J. Arribas, M. D.		
22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/13/66.	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214			25. REC'D BY REGISTRAR DATE JUN 9 1966	25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

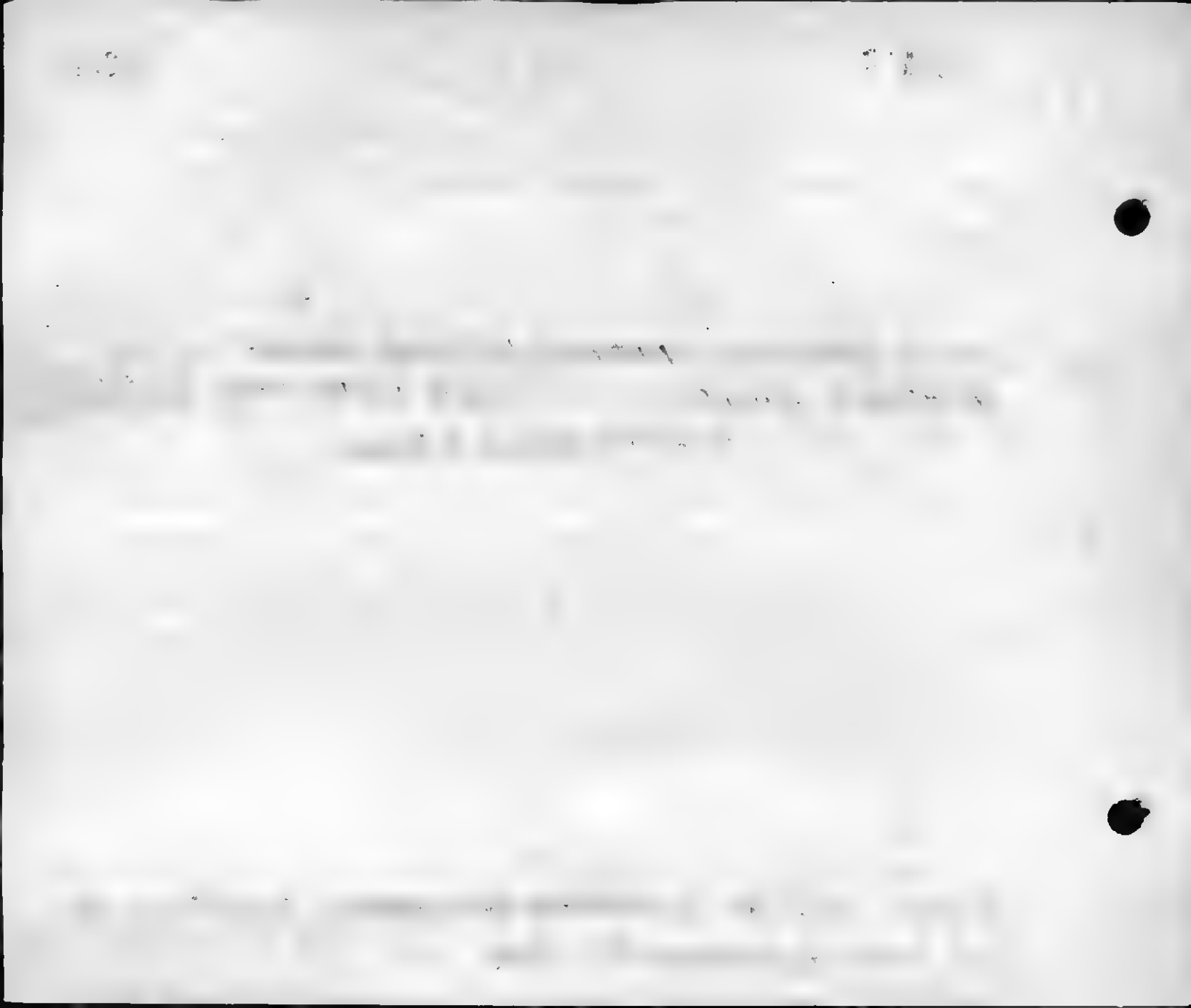
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

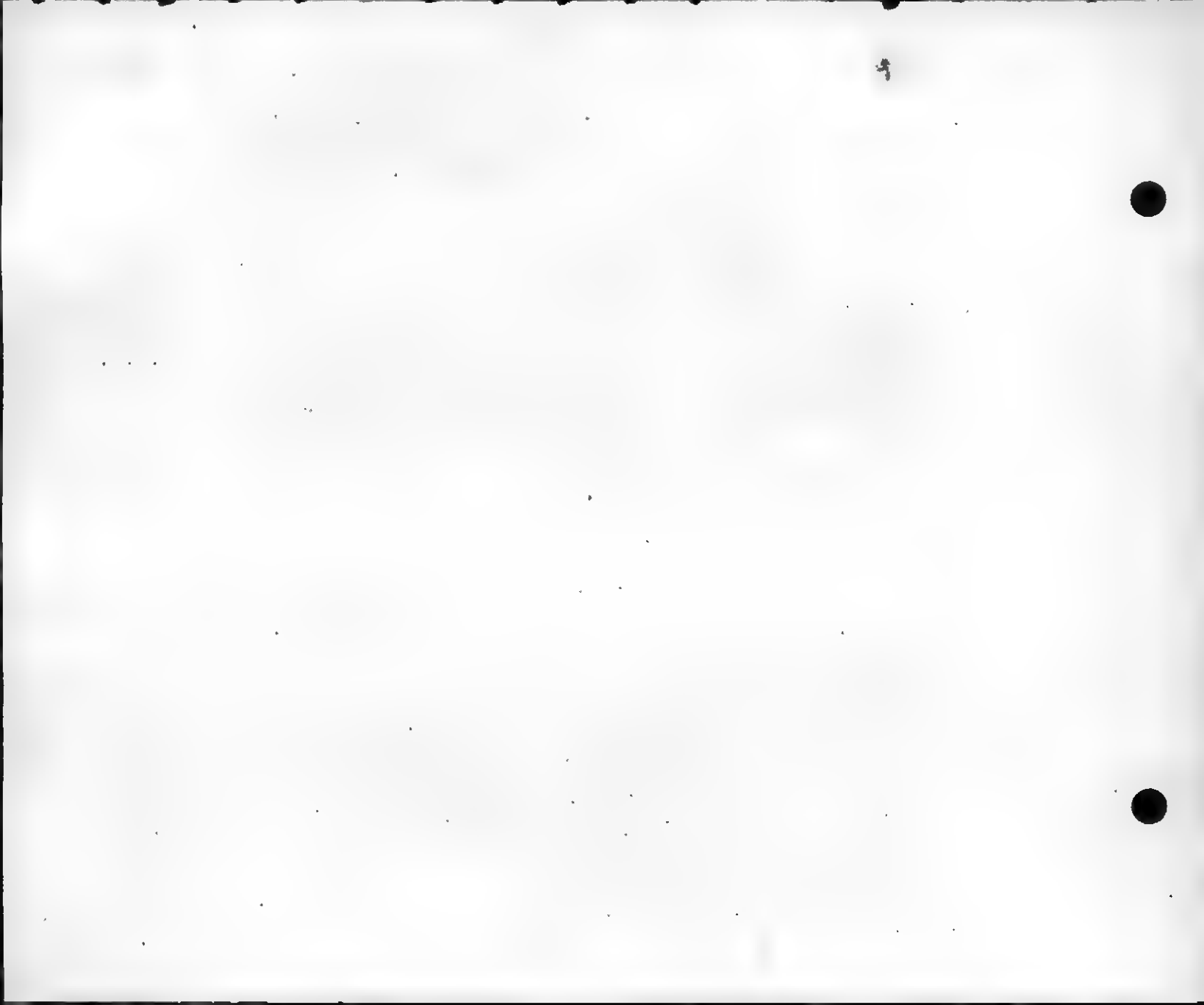
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY CARROLL		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 10 YEARS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER		d. STREET ADDRESS 464 E. GREEN ST.	
3. NAME OF DECEASED (Type or print) ZACHARY NICHOLAS SAMIOS		4. DATE OF DEATH JUNE 3 1966		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 20, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY (RETIRED)		11. BIRTHPLACE (County & State, or foreign country) KYTHERA GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NICHOLAS SAMIOS		14. MOTHER'S MAIDEN NAME TINA KYPRITON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 205-22-4947		17. INFORMANT ARTHUR N. SAMIOS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DIS DUE TO (c) 10 YEARS		INTERVAL BETWEEN ONSET AND DEATH 10 YEARS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>											
20c. TIME OF INJURY Month, Day, Year JUNE 3, 1966 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19 RIDGE ROAD WESTMINSTER MD 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from JUNE 3, 1966 to JUNE 6, 1966 that (I) (we) last saw the deceased alive on JUNE 3, 1966 and that death occurred at 9 AM from the causes and on the date stated above.											
22a. SIGNATURE Daniel I. Welliver M.D. 22b. DATE SIGNED 6-3-66											
22c. PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER 22d. ADDRESS 19 RIDGE ROAD WESTMINSTER MD											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 6/6/66 23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDENS 23d. LOCATION (City, town or county) (State) FINKSBURG, MD											
24. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr., Westminster, Md. 25a. REC'D BY REGISTRAR JUN 6 1966 25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

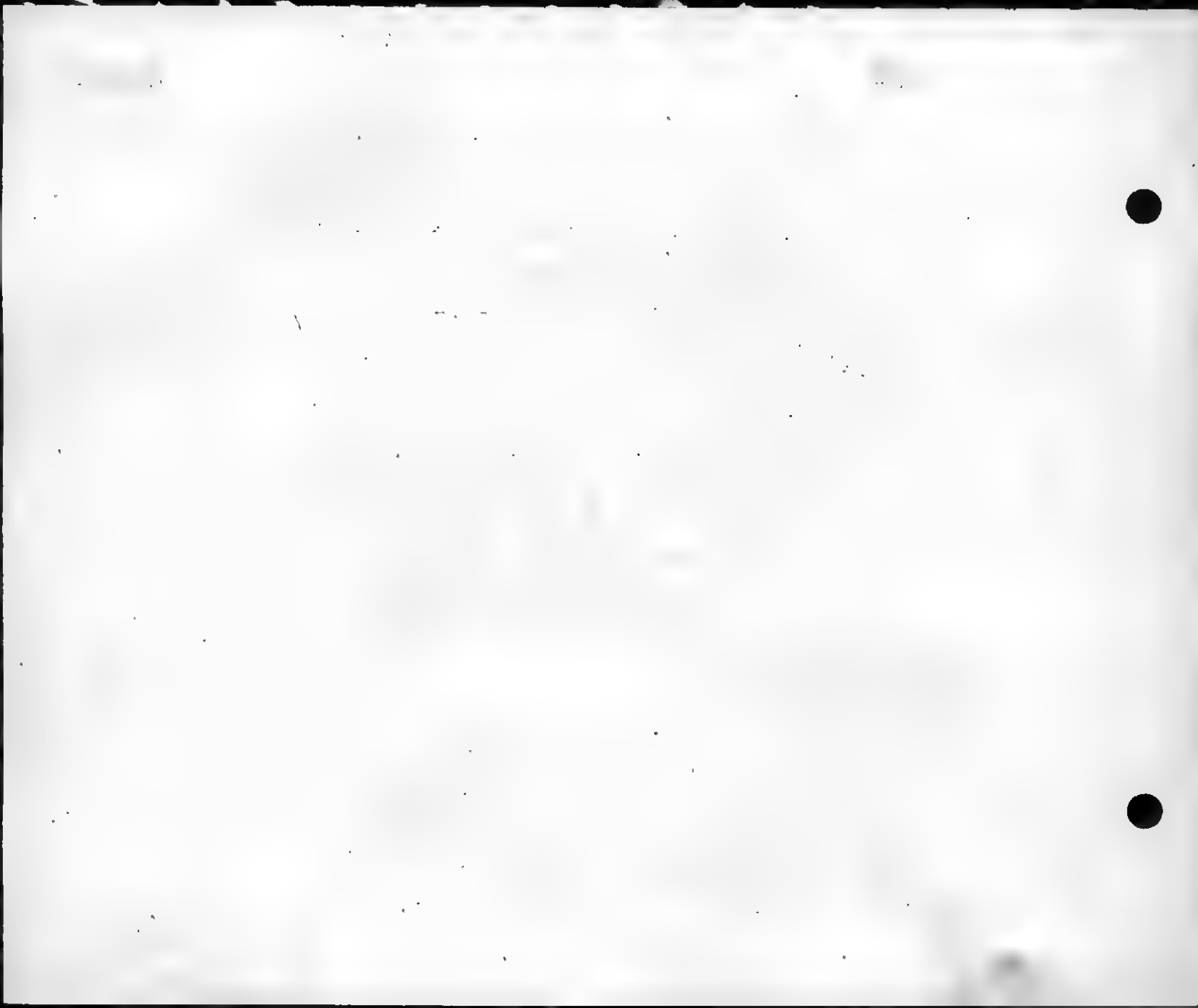
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural -- Sykesville				c. LENGTH OF STAY IN 1b 10 days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clear Spring, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Route # 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Helen Bessie Seibert				4. DATE OF DEATH Month Day Year June 27 1966							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1900		9. AGE (in years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Wilson, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Franklin Hull				14. MOTHER'S MAIDEN NAME Margaretta Catherine Coon							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-34-0935		17. INFORMANT Address Springfield Hospital Records, Sykesville					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion X CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) Cardiac Failure DUE TO (c) CBS associated with alzheimer's disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS associated with cerebral arteriosclerosis with psychosis											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from June 17, 1966, to June 27, 1966, that (he/she) last saw the deceased alive on June 27, 1966, and that death occurred at 2:15 PM from the causes and on the date stated above.											
22a. SIGNATURE Luis J. Arribas				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) Luis J. Arribas, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 30, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d. LOCATION (City, town or county) (State) St. Paul, Washington Co., MD			
24. FUNERAL DIRECTOR ADDRESS Thompson Funeral Home, Clear Spring, Md.				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sikesville</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Carroll</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sikesville Dundalk</u>	
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Guest Home</u>						d. STREET ADDRESS <u>718 McCabe Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Agnes Seymour</u>		First <u>Agnes</u> Middle <u>Seymour</u> Last <u>Seymour</u>		4. DATE OF DEATH <u>June 12 1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-27-1895</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Whittie</u>						14. MOTHER'S MAIDEN NAME <u>Mary O'Neill</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>William W. Seymour</u> Address <u>718 McCabe Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO (b) <u>Parkinson Disease</u> DUE TO (c) <u>Syr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/5/1958</u> , 19 <u>58</u> , to <u>June 12 1966</u> , that (I) (we) last saw the deceased alive on <u>June 12 1966</u> , and that death occurred at <u>8:00</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>W. H. Martin</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 12-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>W H MARTIN</u>						22d. ADDRESS <u>Westminster Ind.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u> ADDRESS <u>Baltimore, Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

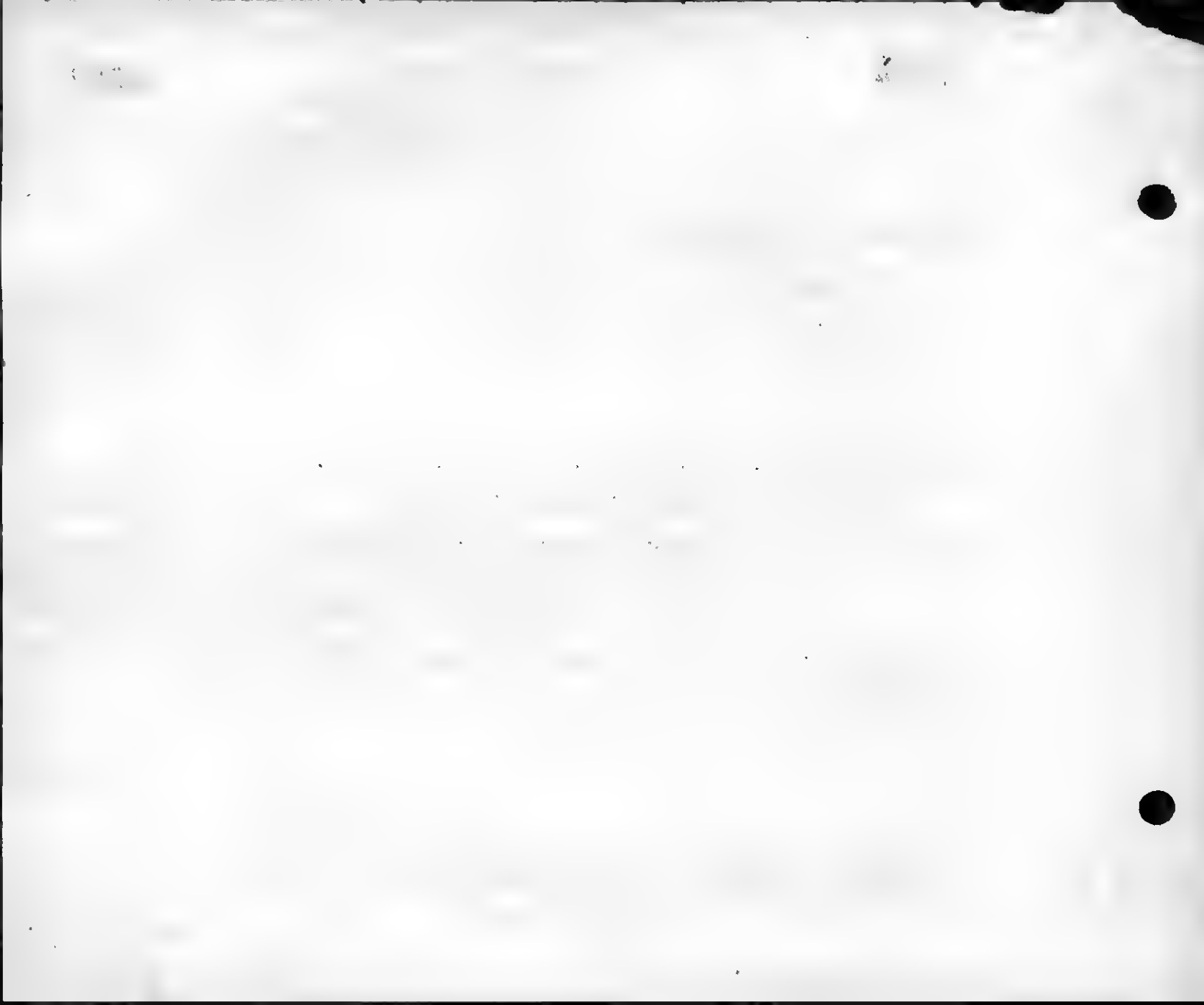
CERTIFICATE OF DEATH

08304

08292

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sykesville</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Manchester</u> d. STREET ADDRESS _____			
3 NAME OF DECEASED (Type or print) <u>Sheridan Phillip</u> <u>Sheffer</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Male</u> 6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4-4-96</u> 9 AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS. Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifford Sheffer</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Dykeman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO <u>113-14-0285</u>		17. INFORMANT <u>Springfield Hospital Records, Sykesville</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>C.B.S. Cerebral Arteriosclerosis & Psychotic Reaction</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from <u>6-3</u> , 19 <u>66</u> , to <u>6-24</u> , 19 <u>66</u> , that we (we) last saw the deceased alive on <u>6-24</u> 19 <u>66</u> , and that death occurred at <u>6:35 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/24/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. Arango - M.D.</u>				22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Manchester Carroll Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton-Eline Fun. Home</u> <u>Hampstead, Md.</u>				25a. RECD BY REGISTRAR <u>JUN 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

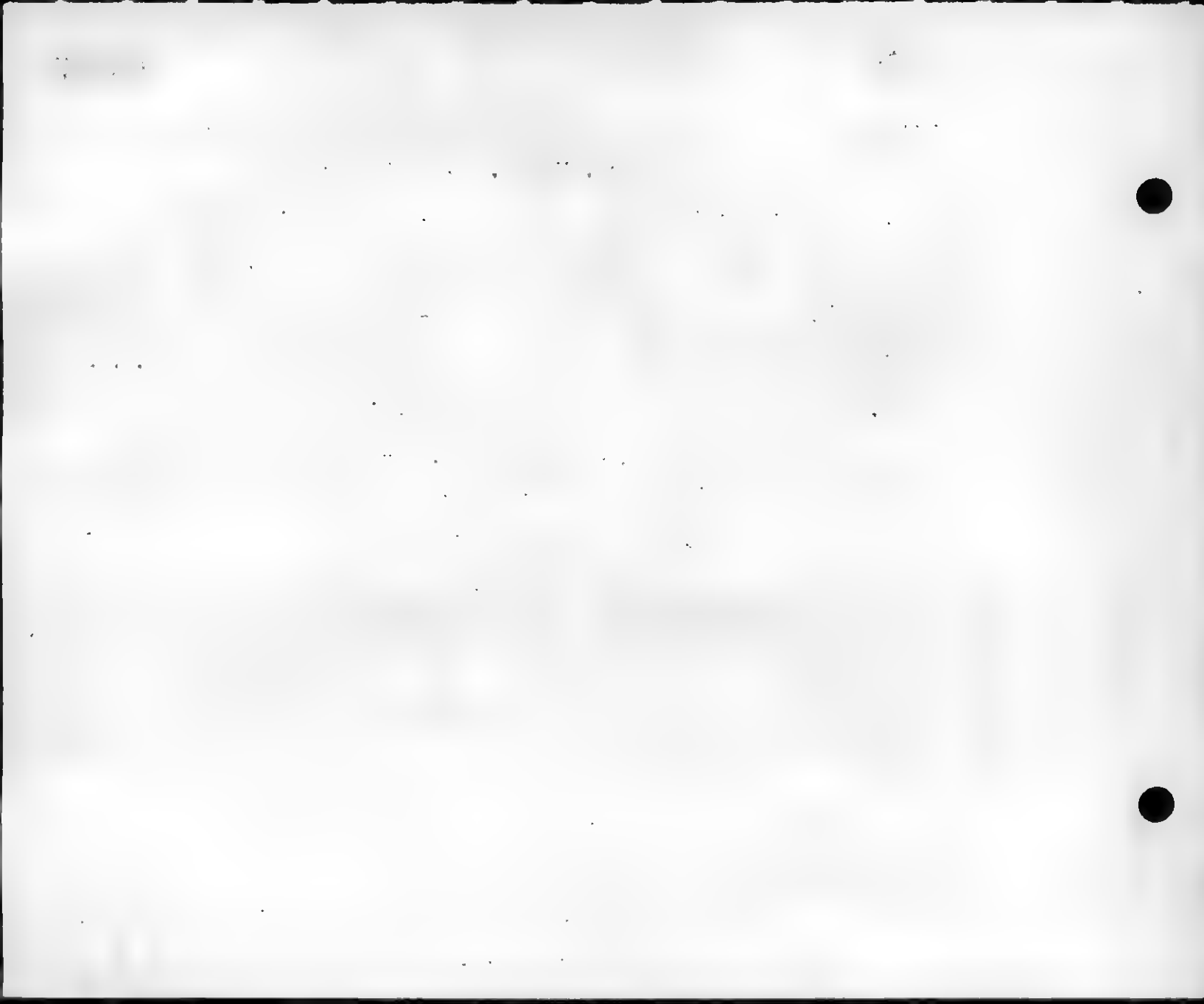
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C8305

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08293

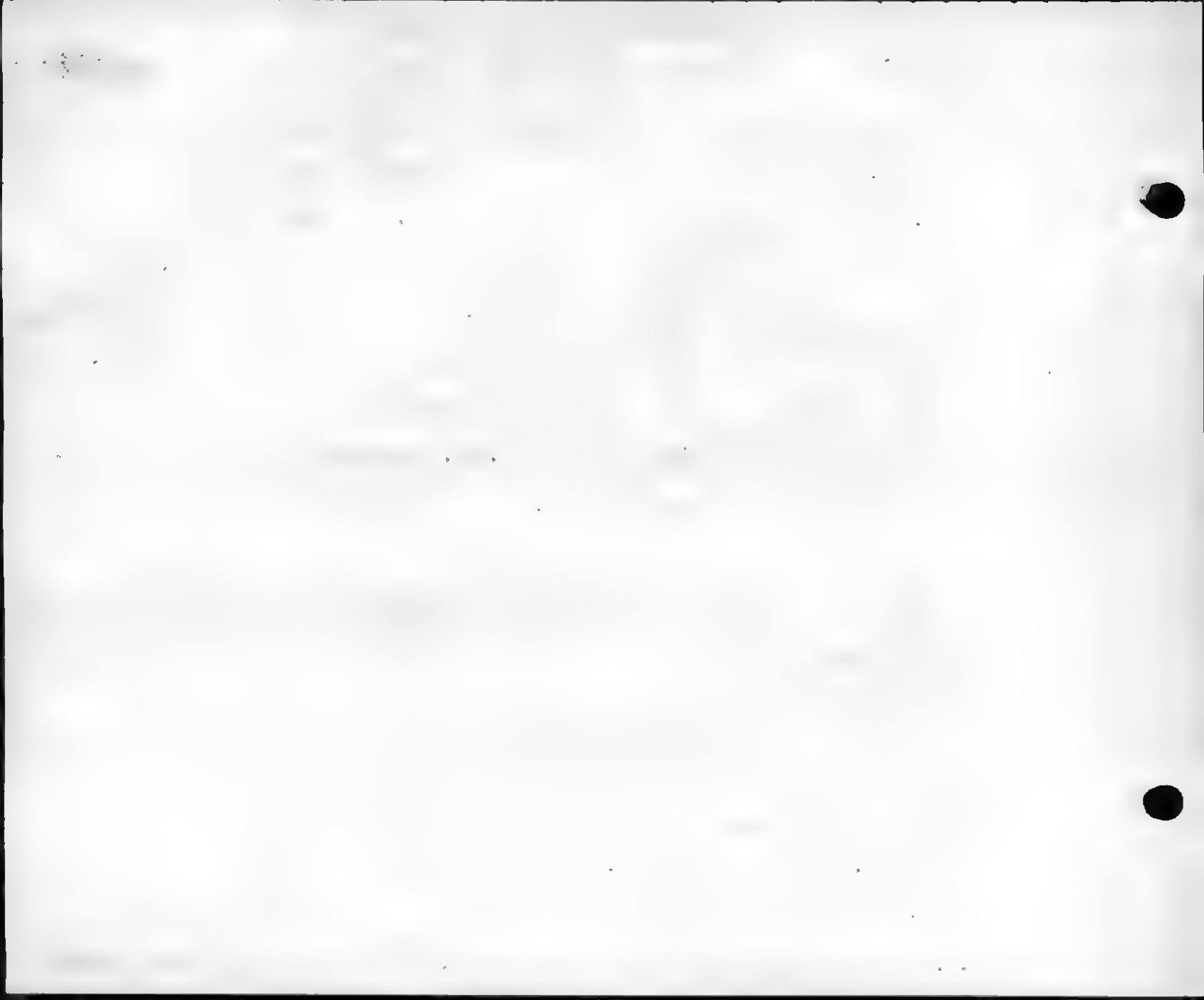
1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY in 1b 2 mos. 11 dys.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 212 Pennsylvania Avenue			
3. NAME OF DECEASED (Type or print) First BERTHA Middle SUZANNA Last SHIPLEY				4. DATE OF DEATH Month June Day 10 Year 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-76	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Bush			14. MOTHER'S MAIDEN NAME Eleanor Murray				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-0257		17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic - C-V Disease DUE TO (c) Bilateral Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arterio-sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M.C. Porterfield		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 6-10-66			
EXAMINER'S NAME (Type) M.C. PORTERFIELD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Hampstead, Carroll, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/13/66	23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery Westminster Md.		23d. LOCATION (City, town or county) (State) Westminster Md.			
24. FUNERAL DIRECTOR L. E. Myers, Jr. Westminster, Md.		25a. REC'D BY REGISTRAR JUN 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY	
Carroll		Rural Taneytown		MARYLAND		Maryland		Carroll	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		R.F.D. # 1M		d. STREET ADDRESS		R.F.D. # 1M		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
Fred		Shoemaker				June 1, 1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
Male		White				Apr. 26, 1892		74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired laborer		Rubber footwear		Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
John Shoemaker		Mary Stuller							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		215-20-9118		Mrs. Ed. Ricketts, R # 1M, Taneytown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis (acute)		INTERVAL BETWEEN ONSET AND DEATH		Several days			
4201		DUE TO		Arterio Sclerosis (hard)		Several yrs			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b)							
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)			
19									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		W. Glenn Speicher, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED			
				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-1-66			
EXAMINER'S NAME (Type)		W. Glenn Speicher, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)			
Burial		June 4, 1966		Reformed Cemetery		Taneytown, Maryland			
24. FUNERAL DIRECTOR		C.O. Fuss & Son (John H. Skiles) Taneytown, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				JUN 3 1966		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

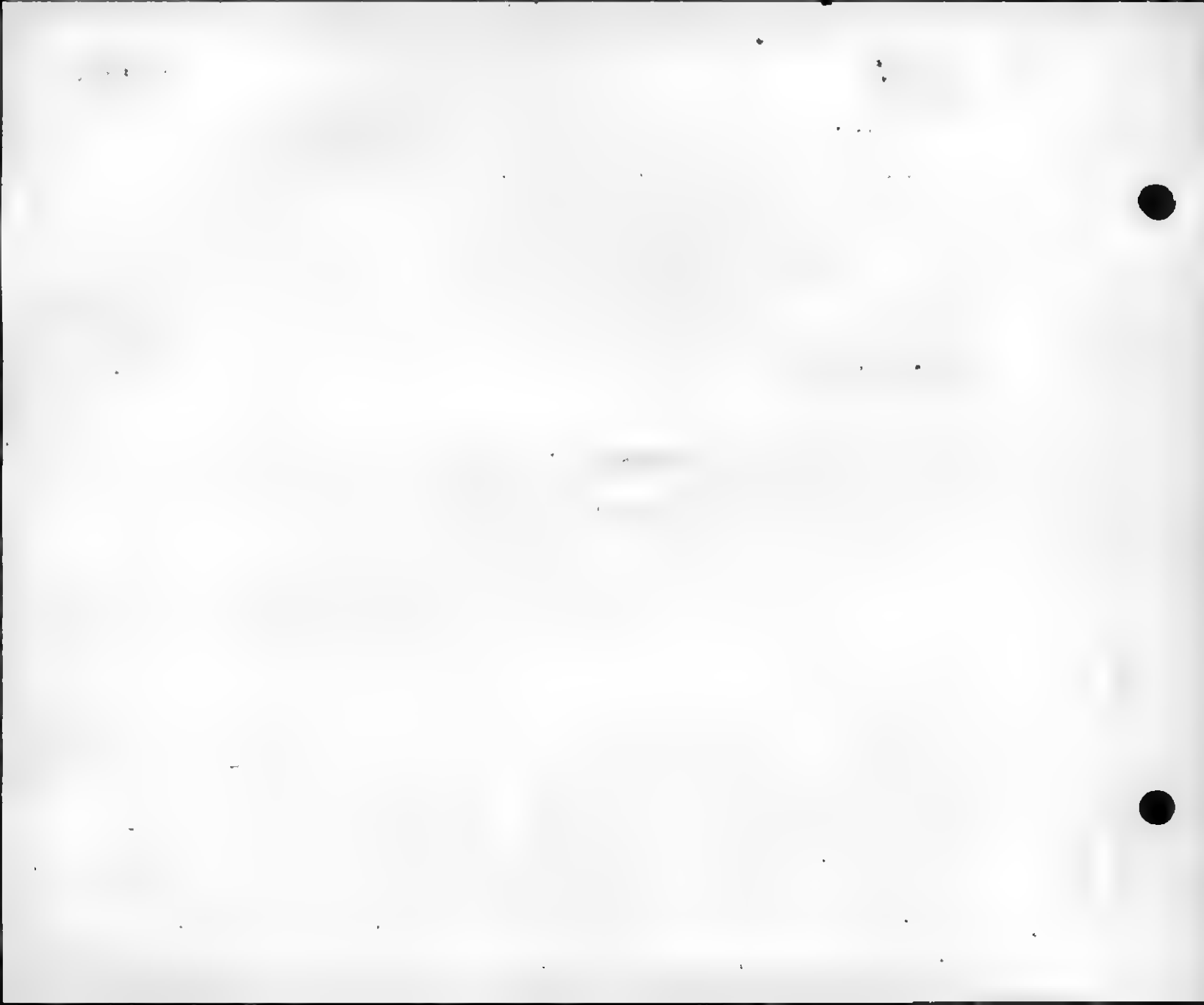
C8307

CERTIFICATE OF DEATH

08295

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2 years 4 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3913 Fairview Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Carroll</u> Middle <u>Smith</u> Last		4 DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-18-95</u>
9 AGE (In years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Julia Butler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-74-9148</u>	
17. INFORMANT <u>Springfield State Hospital Records</u>		Address <u>Sykesville Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-24-61</u> , 19 <u>61</u> , to <u>6-19-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> 19 <u>66</u> , and that death occurred at <u>7:05 a</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. Samuel Wise III</u>		22b. DATE SIGNED <u>6-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Samuel Wise III</u>		22d. ADDRESS <u>Springfield State Hosp. Sykesville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>June 22, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wt. Auburn Cem. Balto Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Williams Funeral Home 319 W. Schroeder St</u>		25a. REC'D BY REGISTRAR <u>JUN 22 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

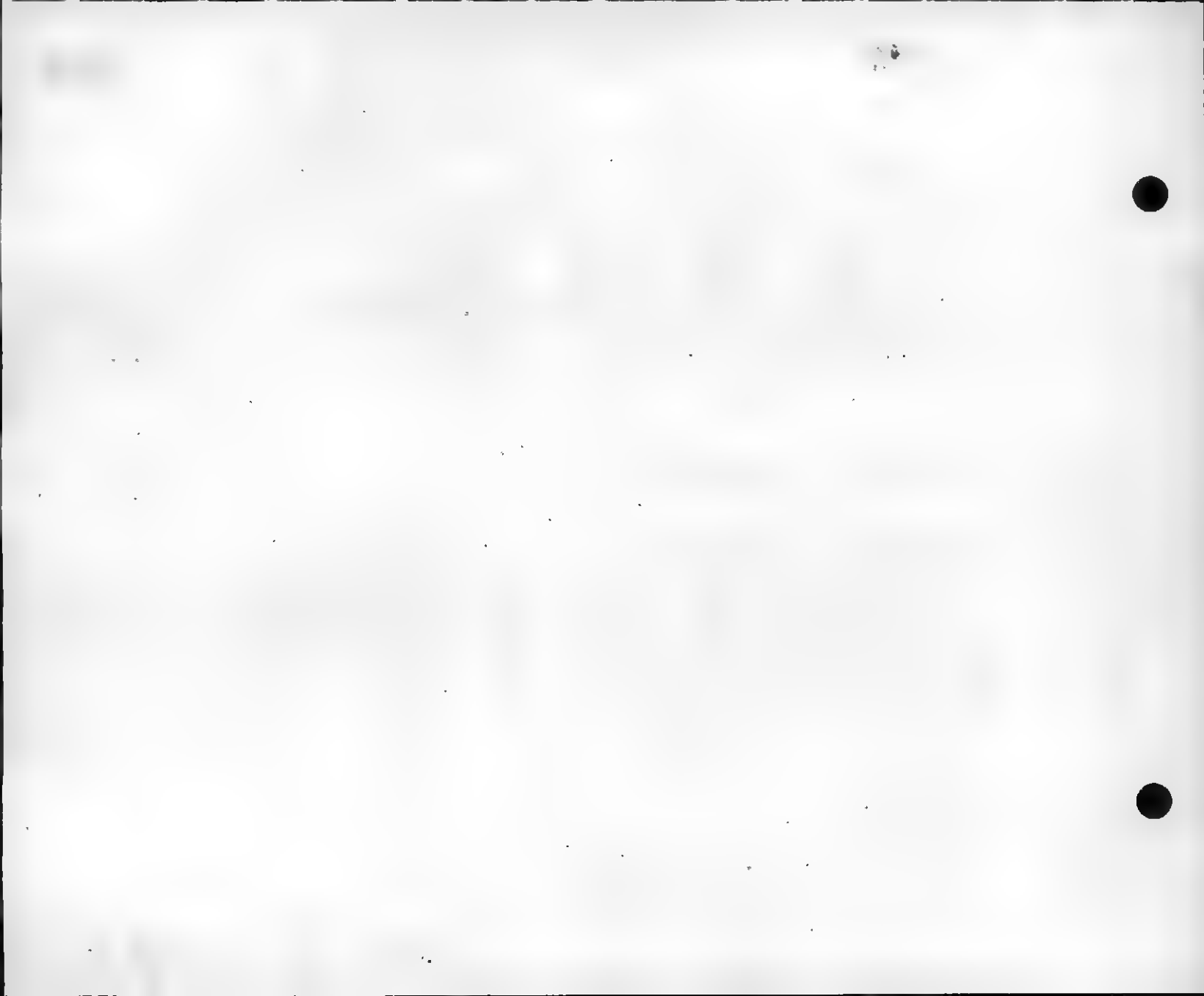
VR AISM (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08308

08296

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown c. LENGTH OF STAY IN ID 24-48 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown, d. STREET ADDRESS 41 York Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Scott Last Smith		4. DATE OF DEATH June 12 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Scott McClellan Smith	
14. MOTHER'S MAIDEN NAME Carrie Belle Clutz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-32-1470		17. INFORMANT Mrs. Walter S. Smith Address 41 York Street Taneytown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis C.V. Disease DUE TO (b) Arteriosclerosis C.V. Disease DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Maurice C. Porterfield EXAMINER'S NAME (Type) Maurice C. Porterfield		22. DATE SIGNED 6-13-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) HARRISTEAD, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/16/66	23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	23d. LOCATION (City, town or county) (State) Taneytown Maryland
24. FUNERAL DIRECTOR John H. Skiles John H. Skiles		25a. REC'D BY REGISTRAR JUN 15 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C8309

CERTIFICATE OF DEATH

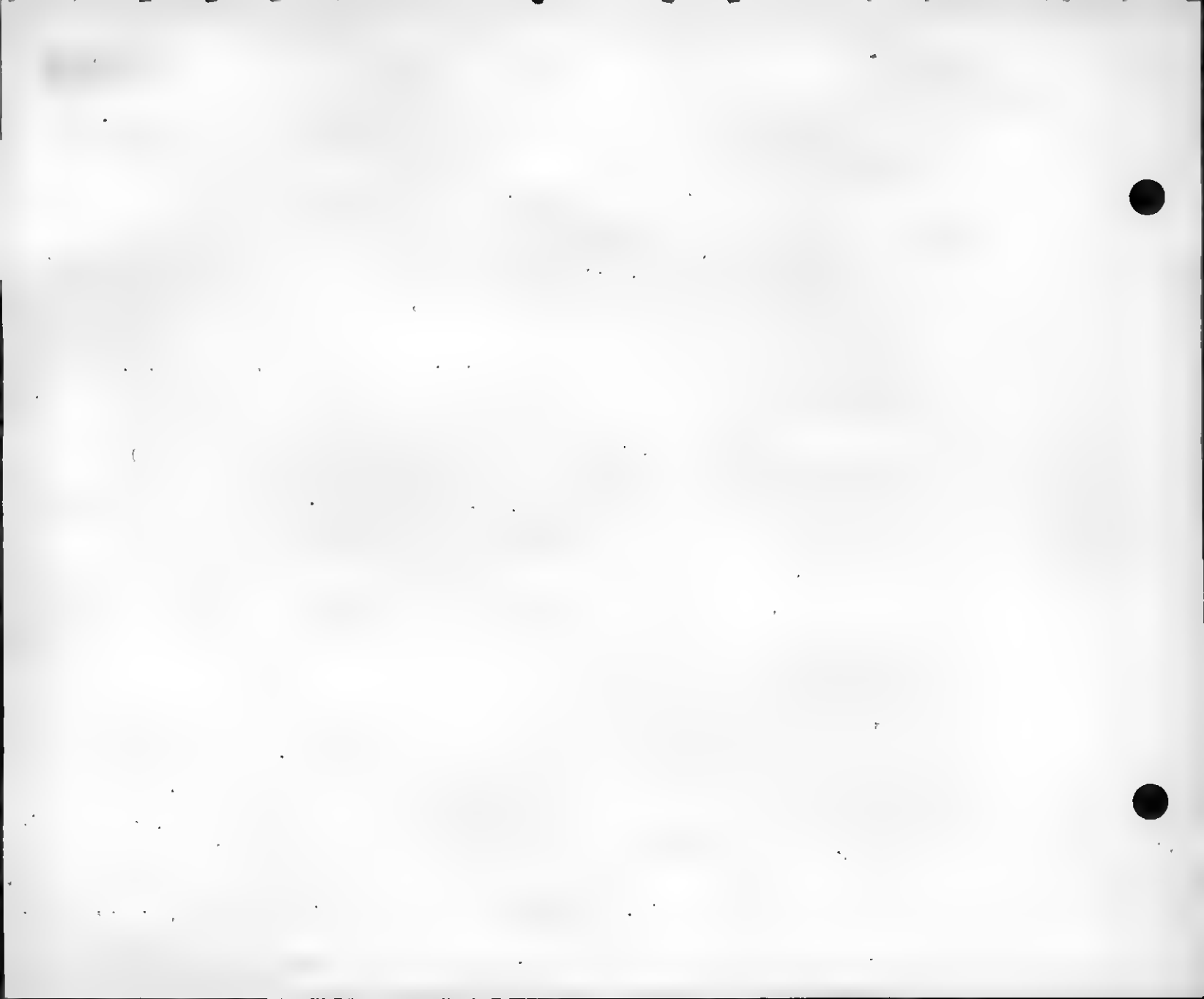
08297

1. PLACE OF DEATH a. COUNTY Carroll County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers c. LENGTH OF STAY IN ID Box 196 Route 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 196 Route 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millers d. STREET ADDRESS Box 196 Route 1 21107 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anton Middle Wells Last Steiner		4. DATE OF DEATH Month June Day 22 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.27.1890
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min. 75	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		11b. KIND OF BUSINESS OR INDUSTRY Plumbing and Heating	
12. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Anton Steiner		15. MOTHER'S MAIDEN NAME Ann Herald	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Mrs. Gertrude B. Steiner		Address same address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of throat & metastasis 14 x 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 14 x 1 DUE TO (c) 14 x 1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 14 x 1			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/18 , 19 65 , to 6/22 , 19 66 , that (I) (we) last saw the deceased alive on 6/22 , 19 66 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE P. A. Knight		22b. DATE SIGNED 6/23/1966	
22c. PHYSICIAN'S NAME (Type) P. A. Knight		22d. ADDRESS Greenmount Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/25/1966	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cemetery		23d. LOCATION (City, town or county) (State) Elkridge, Md.	
24. FUNERAL DIRECTOR Wm. J. Fickner & Sons		25a. REC'D BY REGISTRAR Balto., Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUN 23 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County Hospital</u>				d. STREET ADDRESS <u>2017 Sandy Spring Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNIE E. TAYLOR</u>		4. DATE OF DEATH <u>June 4 1966</u>		5. SEX <u>Female</u>		6. COLOR <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Aug 13, 1884</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>P. G. Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Doyle</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Reed</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218 20 0358</u>		17. INFORMANT <u>Milton Taylor Same as #2 (son)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 26 1963</u> to <u>June 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 4 1966</u> , and that death occurred at <u>4:15</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Mastin</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 4-66</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. MASTIN</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Beltsville P. G., Md.</u>			
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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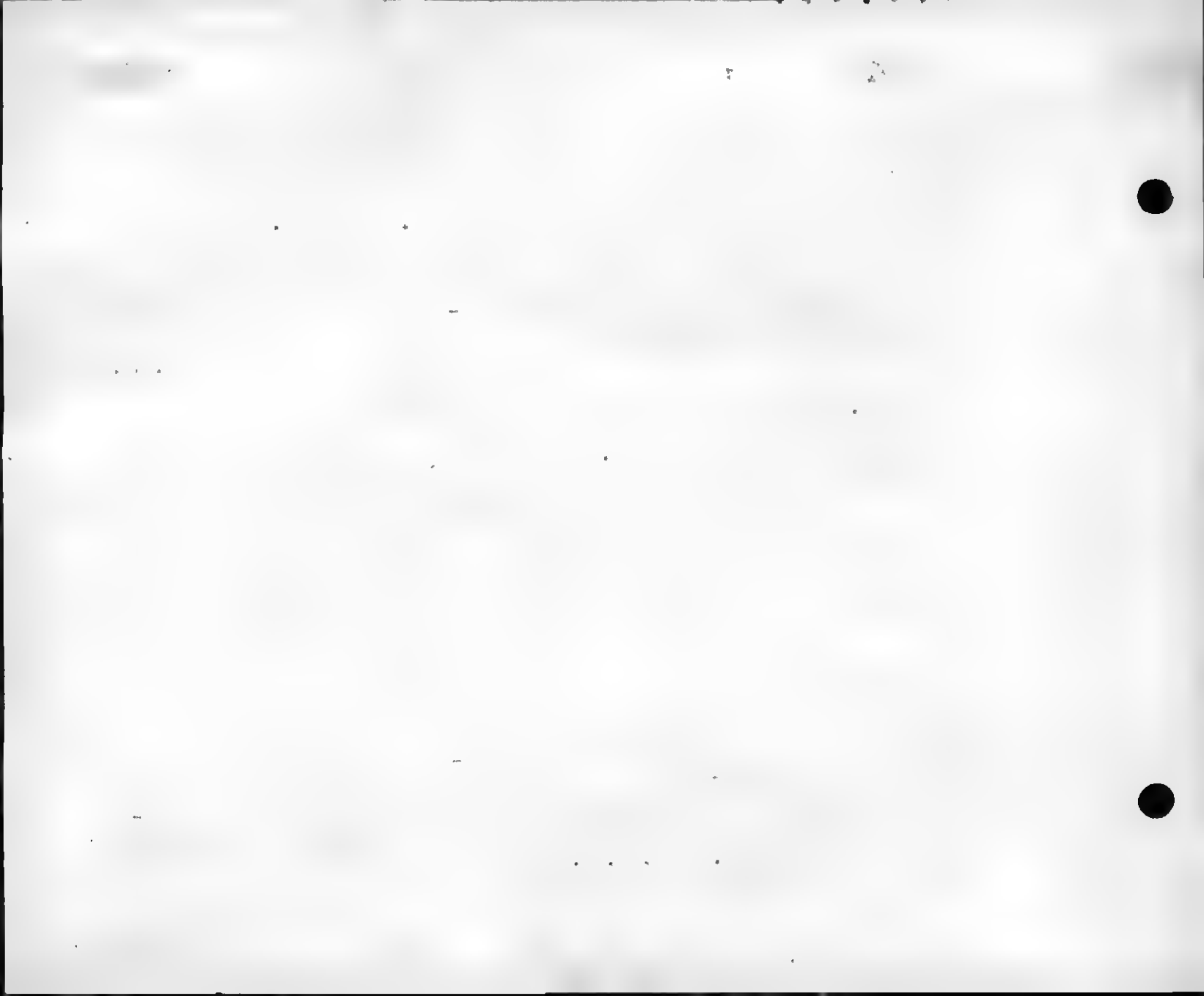
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08311

CERTIFICATE OF DEATH

08299

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1506 W. Mosher St.	
3. NAME OF DECEASED (Type or print) First Middle Last ARCHIE THEODORE THOMAS		4. DATE OF DEATH Month Day Year JUNE 3 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-31
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M. Thomas		14. MOTHER'S MAIDEN NAME Rose Finetta	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bilateral bronchopneumonia 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-22-66 , 19__ to 6-3-66 , 19__, that (I) (we) last saw the deceased alive on 6-3-66 , 19__, and that death occurred at 10:00 AM from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 6-3-66	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE THEREOF 6/7/66	
23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetry		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Robert J. Hestead		25a. REC'D BY REGISTRAR JUN 6 1966	
ADDRESS 1206 W. North Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C8312

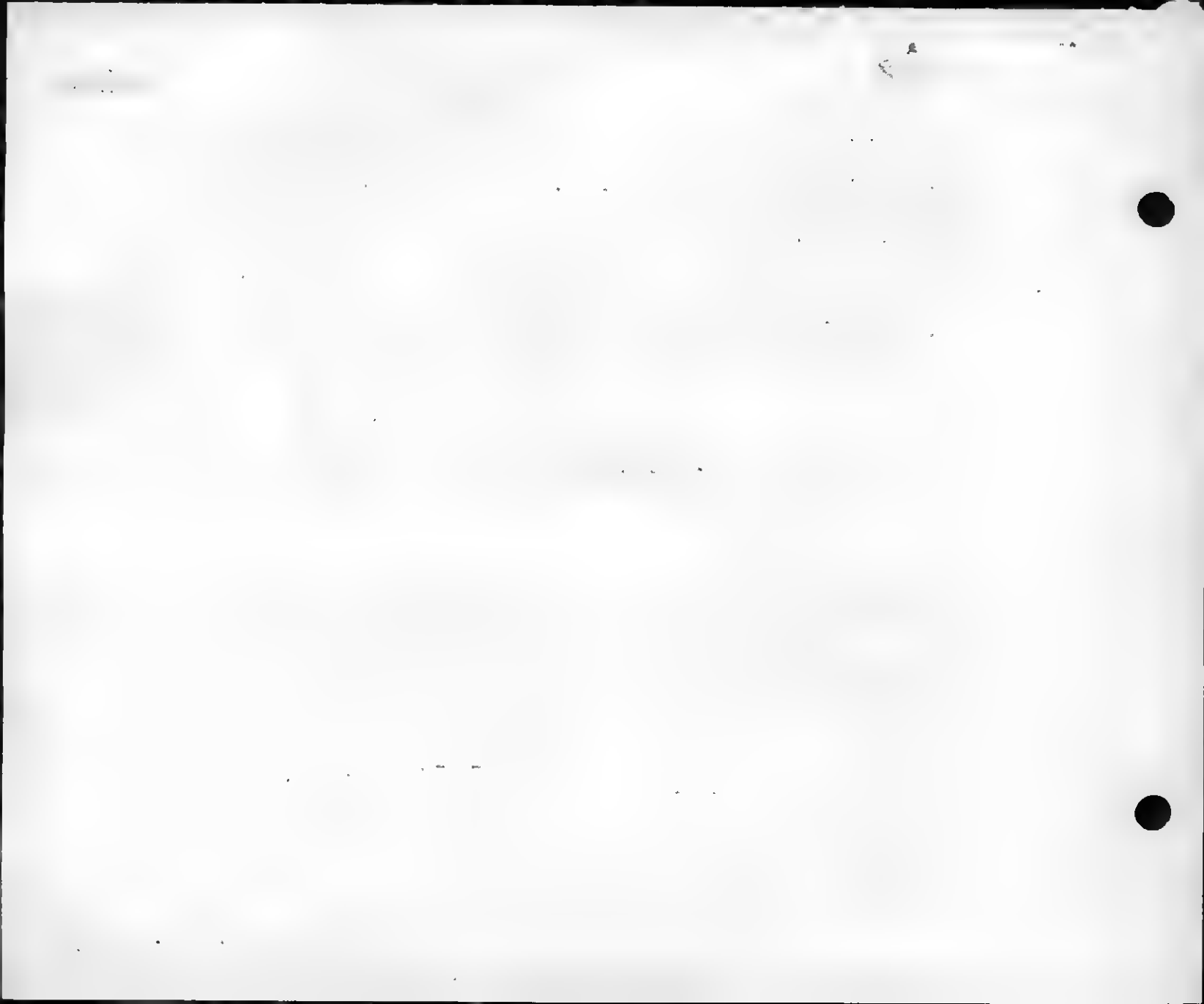
CERTIFICATE OF DEATH

08300

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs 6 mos. 17 da</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		d. STREET ADDRESS <u>Springfield State Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Georgianna</u> Middle <u>Barrett</u> Last <u>Todd</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/23/76</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ellis Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Meekins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>4-22-22-22</u>	
17. INFORMANT <u>Springfield State Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Senile Brain Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-24-66</u> , 19 <u> </u> to <u>6-10-66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>6-10-66</u> , 19 <u> </u> , and that death occurred at <u>12:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alberto D. Arengo</u>		22b. DATE SIGNED <u>6/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alberto D. ARENGO, M.D.</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>North East Meth. North East, Md.</u>		23d. LOCATION (City or Town) (County) (State) <u>North East, Md.</u>	
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u>		25a. REC'D. BY REGISTRAR <u>JUN 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08314

08302

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>43 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>45 JOHN STREET</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>45 JOHN STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROY LEVI WAGNER</u> First Middle Last		4. DATE OF DEATH <u>JUNE 21</u> 19 <u>66</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1891</u> <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUG MANUF.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO., MD.</u>
13. FATHER'S NAME <u>BENJAMIN WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH FOSSETT (NEPHEW)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-1712</u> 17. INFORMANT <u>ROBERT DOOLE REISTERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last <u>5 YEARS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>NO</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>19 RIDGE ROAD WESTMINSTER MD</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19, 1966</u> to <u>JUNE 21, 1966</u> that (I) (we) last saw the deceased alive on <u>JUNE 20, 1966</u> and that death occurred <u>5:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel I. Welliver</u> M.D.		22b. DATE SIGNED <u>6/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>		22d. ADDRESS <u>19 RIDGE ROAD WESTMINSTER MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>6/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEM.</u> 23d. LOCATION (City, town or county) (State) <u>WINFIELD CARROLL CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08315

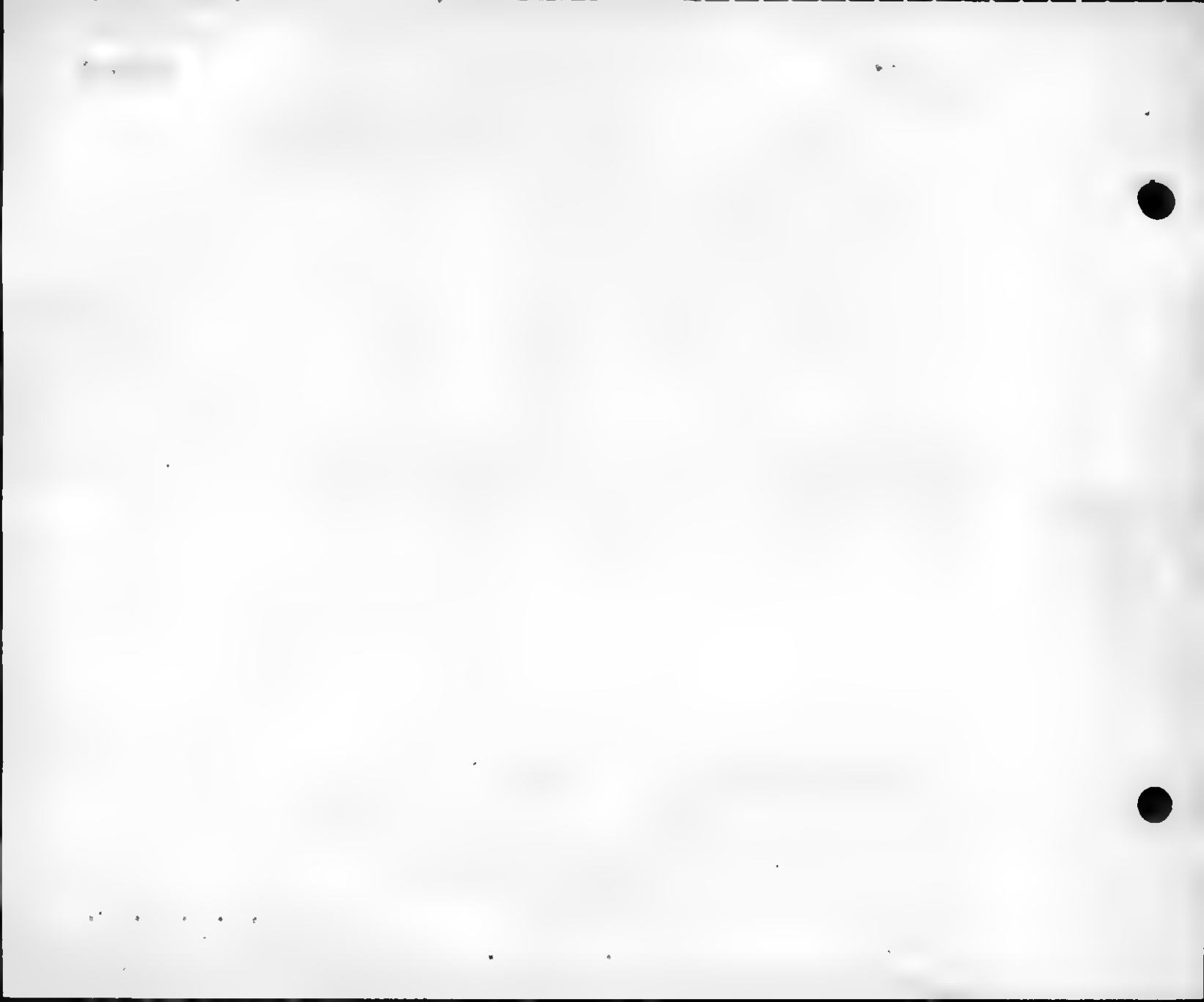
CERTIFICATE OF DEATH

08303

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>35 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>1512 PATAPSCO ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Julius ALBERT WEIDNER</u>		4. DATE OF DEATH <u>JUNE 25 1966</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 7, 1903</u>	
9. AGE (in years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESS OPERATOR</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Julius Edward Weidner</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA SHETTLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chest angiectia (pneumonia)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>65</u> to <u>JUNE 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JUNE 25</u> 19 <u>66</u> , and that death occurred at <u>4:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Hasson A. Salih</u>		22b. DATE SIGNED <u>6/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HASSON A SALIH</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6 29 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, A. A. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Mc Cully</u>		25a. REC'D BY REGISTRAR <u>JUN 28 1966</u>	
ADDRESS <u>130 E. Fort Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08316

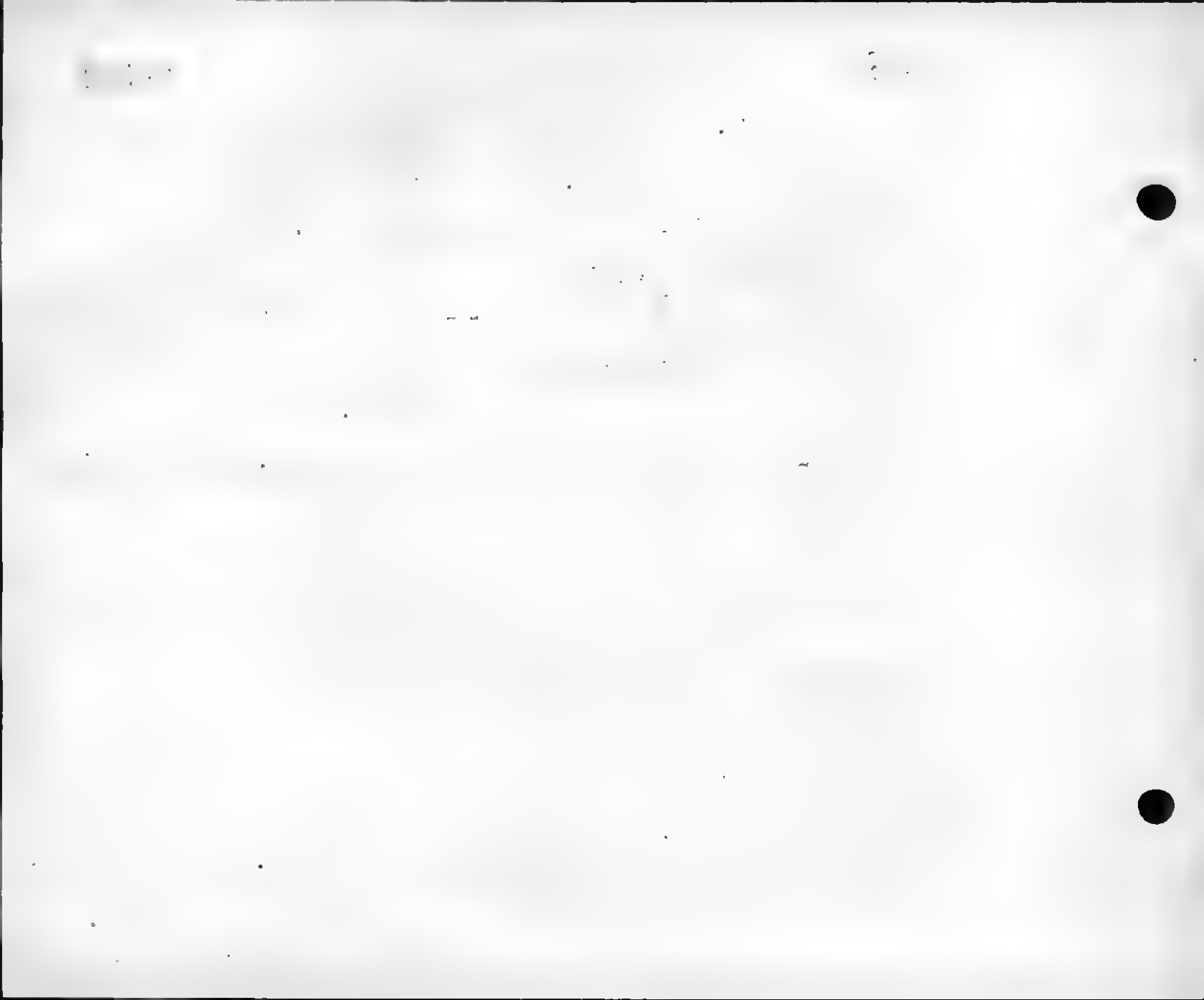
CERTIFICATE OF DEATH

08304

1. PLACE OF DEATH a. COUNTY Carroll Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Tb 5yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 900 Southerly Ave.	
3. NAME OF DECEASED (Type or print) Harry Stansbury Weyrich		4. DATE OF DEATH June 4, 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1888
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 5 Days 2 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Episcopalian	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Weyrich		14. MOTHER'S MAIDEN NAME Grace A. Stansbury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-36-1162	
17. INFORMANT Springfield State Hosp. Records		Address Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO (b) DIABETES MELLITUS DUE TO (c) C.B.S. - A.S.C.V.D.			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS YES YES?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-17, 1961 to 6-4, 1966 that (I) (we) lost saw the deceased alive on 6-4, 1966 and that death occurred at 2:27 PM from causes and on the date stated above.			
22a. SIGNATURE Harri H. Jenkins		22b. DATE SIGNED 6/4/1966	
22c. PHYSICIAN'S NAME (Type) NACI NEWMAN		22d. ADDRESS Springfield St. Hosp. Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6/6/1966	
23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR DA JUN 6 1966	
Address 4905 York Road Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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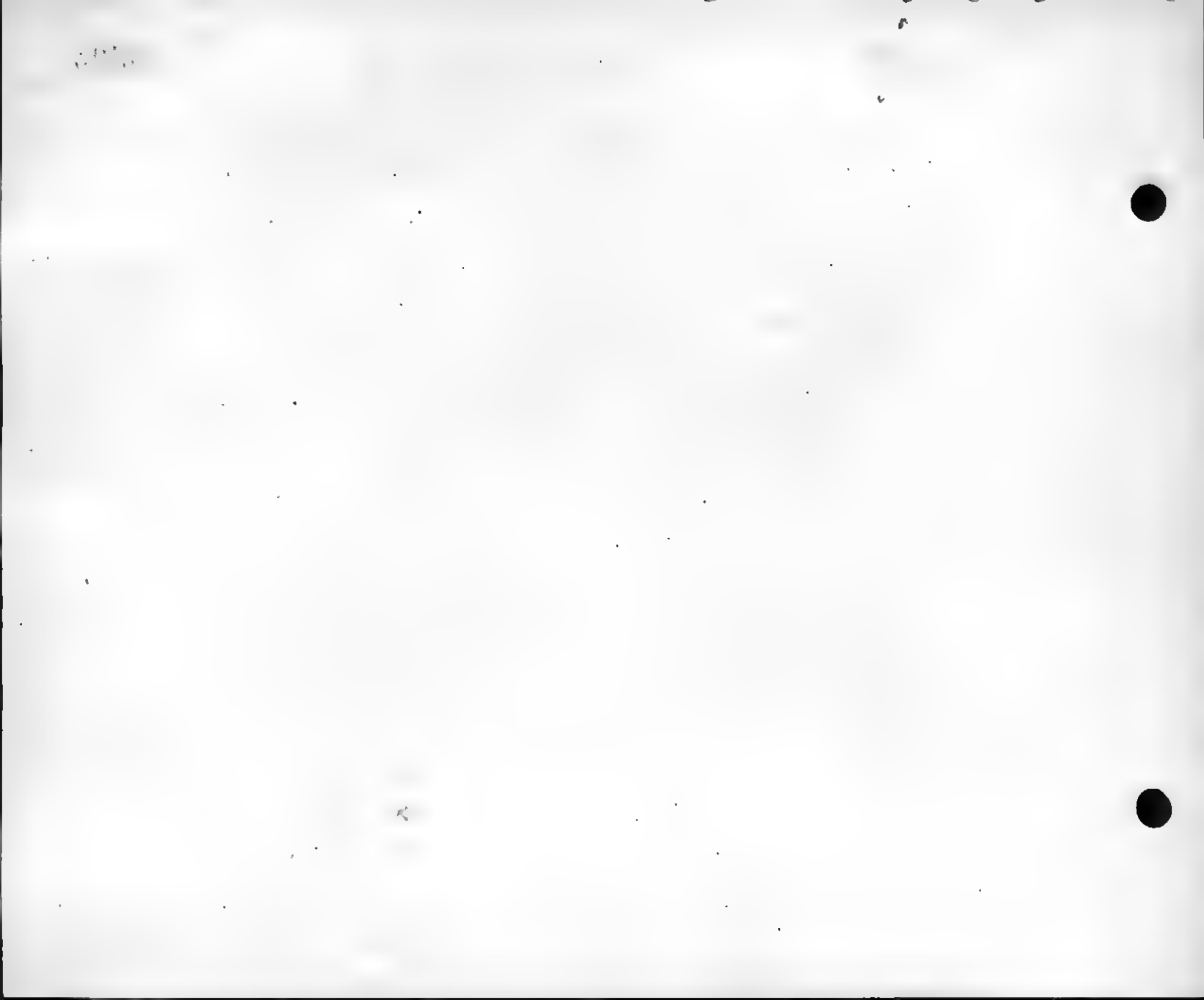
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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08317 CERTIFICATE OF DEATH 08305

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN ID <u>5 Years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pullen Nursing Home</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>			
d. STREET ADDRESS <u>153 E. Green St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Manuel</u> Middle <u>eta</u> Last <u>Riggs</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1884</u>	
9. AGE (in years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13. FATHER'S NAME <u>Elisha Riggs</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ridgely</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. James White</u> Address <u>Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Coronary</u> <u>4201</u> DUE TO (b) <u>Thrombosis, artery, Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1965</u> <u>to</u> <u>6-16-66</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>66</u> to <u>6-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-16</u> , 19 <u>66</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Glenwood Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>JUN 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08313

08306

1 PLACE OF DEATH a COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Frederick		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c LENGTH OF STAY IN 1b 23yrs.4mo.10days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS None		
3 NAME OF DECEASED (Type or print) First Middle Last NORA (M.) WILHIDE			4 DATE OF DEATH Month Day Year June 13 19 66		
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-1-83	9. AGE (In years last birthday) 82 yrs	F UNDER 1 YEAR Months Days Hours Min
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY ----	11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Joseph Wilhide			14. MOTHER'S MAIDEN NAME Julia Freezy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6034	17. INFORMANT Records Address Sykesville, Springfield State Hospital, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with convulsive disorder with psychotic reaction.					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2-3, 1943 , to 6-13, 1966 , that (I) (we) last saw the deceased alive on 6-13, 1966 , and that death occurred at 10:45 A.M. from causes and on the date stated above.					
22a. SIGNATURE <i>Ilse Kamm</i> M.D.			22b. DATE SIGNED June 13, 1966		
22c. PHYSICIAN'S NAME (Type) Ilse Kamm, M.D.			22d. ADDRESS Springfield State Hospital Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-16-66	23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Garden Nr. Frederick Fred. Co.		23d. LOCATION (City or Town) (County) (State) Frederick Md.	
24 FUNERAL DIRECTOR <i>Raymond E. O'Keefe</i> ADDRESS <i>Thermont, Md.</i>			25a. REC'D BY REGISTRAR JUN 15 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

VR A15 (4)
20 M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
08307											
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middleburg c. LENGTH OF STAY IN 1b 4 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brookfield Manor				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodsboro d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Carrie Irene Willhite				4. DATE OF DEATH June 3 19 66							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1893		9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Fogle						14. MOTHER'S MAIDEN NAME Laura V. Keeney					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No				16. SOCIAL SECURITY NO. 214-28-6002		17. INFORMANT Address Mrs. Myra Dorsey Woodsboro, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Cardiovascular Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1961 19 to 6/3/1966 , that (I) (we) last saw the deceased alive on 6/2/66 19, and that death occurred at 9:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE J.H. Caricofe				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/3/66			
22c. PHYSICIAN'S NAME (Type) J.H. Caricofe				22d. ADDRESS Union Bridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6-5-66		23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery				23d. LOCATION (City, town or county) (State) Nr. Woodsboro Fred. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		25. FILED BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

08303

08303

U.S. Mail

Postage

Postoffice

Carrie Grace Williams

Female White

born

born

Edward Lewis

321-25-0000

No

Union Village, Mo.

St. Louis, Mo.

4-2-00

4-2-00

St. Louis, Mo.

St. Louis, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08320

CERTIFICATE OF DEATH

08308

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1 mo. 4 dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 804 SOUTH RIDGE RD.	
3. NAME OF DECEASED (Type or print) First Middle Last KARL ADOLF ZIMMERMAN		4. DATE OF DEATH Month Day Year June 14 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-01
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY CAN CO.	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A. Natural-ized.	
13. FATHER'S NAME Anton Zimmerman		14. MOTHER'S MAIDEN NAME Sophia Stocker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-4125	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 4201 DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH hours years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-10-66 , 19__, to 6-14-66 , 19__, that (I) (we) last saw the deceased alive on 6-14-66 , 19__, and that death occurred at 2:27 A.M. causes and on the date stated above.			
22a. SIGNATURE Hassan A. Salih,		22b. DATE SIGNED 6-14-66	
22c. PHYSICIAN'S NAME (Type) Hassan A. Salih, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6-18-66	
23c. NAME OF CEMETERY OR CREMATORY Catholic Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Starky Cronough 576-00-1		25a. REC'D BY REGISTRAR JUN 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1995-1996

— *Journal of the American Medical Association*